Clinical Psychologists as Multi-Disciplinary Team Managers in Mental Health Services: A Grounded Theory Study

Sarah Louise Titchen

Thesis submitted in partial fulfilment of the requirements of Staffordshire and Keele Universities for the jointly awarded degree of

Doctorate in Clinical Psychology

July 2015

CANDIDATE DECLARATION

Title of degree programme	Doctorate in Clinical Psychology
Candidate name	Sarah Titchen
Registration number	11027437
Initial date of registration	September 2012

Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: Date:

Acknowledgements

I would like to thank my wonderful husband for doing everything he could to support me in this project, without you I wouldn't have had the courage to apply for the doctorate, much less get to the other side. Thank you to my beautiful daughter Isla for motivating me to try to get my thesis done before she arrived, and thank you for sleeping while I got it finished after you arrived early.

To the course staff who helped to make this possible in challenging circumstances, thank you, in particular, Professor Helen Dent and Doctor Helena Priest. Thank you to my field supervisor Doctor Felix Davies for the continued support.

A huge thank you to the participants who consented to be a part of my research, you made this an interesting project to complete and without you the project would not have been possible. I appreciate the time you gave to participate in your incredibly busy schedules.

Contents

List of tables

Chapter 1

Chapter 2

List of Figures

Chapter 1

Chapter 2

Chapter 3

Thesis Abstract

This thesis comprises three chapters: a literature review, an empirical paper and a reflective paper. The literature review evaluates papers describing the impact on staff of changes to mental health organisations in United Kingdom (UK). The different changes to the organisations are considered and the factors influencing change are identified alongside a critique of the identified papers. Different theories explaining the processes of organisational change are provided. The change theories, combined with the findings from the papers, are appraised and amalgamated to propose a model for organisational change in mental health services.

The empirical paper reports on a grounded theory exploration of clinical psychologists as multi-disciplinary team (MDT) managers in National Health Service (NHS) mental health services. Positive professional experiences of leadership are associated with a move to MDT management. The decision to move to management ranges from a concrete early career decision to a perception that the organisation requires the participant to move into management. The steps to pursue management roles and the barriers faced are outlined. The central concept of participants' experiences of being a manager is how they construct their identity and how this is shaped by interaction with the organisation and individuals. In addition, the way participants view themselves and are viewed by others was shaped by the medical model, service user focus, threat and time. These findings are linked to narrative models of identity and discussed in the context of existing literature on psychologists and leadership.

The reflective paper explores the experience of conducting the research, specifically overcoming the barriers of gaining ethical approvals and recruitment and understanding how psychological defences can impact on the research journey. As this paper includes consideration of personal experiences and psychological defences it is written in the first person.

The journal targeted for the literature review is the Journal for Change Management. The journal targeted for the Empirical Paper is the British Journal of Clinical Psychology.

Chapter 1: Literature Review

A Literature Review of Support Provided to Mental Health Service Staff During Organisational Change Within the UK National Health Service

Abstract

Change in NHS mental health services is frequent as services are adapted to new technologies, government guidelines and social and political pressures. By reviewing the literature on change in NHS mental health services since the publication of New Ways of Working for Everyone (NWW, DoH, 2007b), a better understanding of the types of changes facing staff in services is provided alongside a brief summary of the main types of organisational change theories. Nine papers are reviewed that focus on the experiences of staff in mental health services where a change was implemented to the service. The selected literature is described and the results of the thematic analysis presented to identify what support helps staff in coping and adapting to change. From this, a model for organisational change in NHS mental health services is proposed. Limitations of the review, implications for practice and suggestions for further reviews are provided.

Keywords: NHS; Mental Health Services; Organisational Change; Staff; Experiences

Introduction

Care for those experiencing mental health difficulties in the United Kingdom (UK) is undertaken by the National Health Service (NHS), and private and voluntary organisations. In the NHS, mental health services provide care for a range of mental health difficulties in a variety of different services including those for adults, children, young people and their families, older adults, and people with a learning disability. The size and structure of the teams providing care in these services varies according to service need and availability of resources. The NHS in the UK is frequently subject to change in response to government agendas, healthcare guidelines, and financial pressures, often focussing on short term change rather than long term transformation (Ham, 2014). Some of the difficulties resulting from change are increased staff stress (Khandaker, Cherukuru, Dibben & Kar Ray, 2009), difficulties in retention of staff (Kelly & Humphrey, 2013) and feelings of uncertainty (Astbury, Lovell, Mason & Froom, 2011). Mental Health services have undergone significant structural change over the past few decades with the development of the National Service Framework for Mental Health, the move to

more community services, and more recently a focus on cost improvements. Guidelines from organisations such as the National Institute for Clinical Excellence (NICE), Royal College of Psychiatrists (RCPsych) and the Department of Health (DoH) have influenced the delivery of services to people with mental health difficulties and the staff employed in mental health services. In 2005, New Ways of Working for Psychiatrists (DoH, RCPsych and National Institute for Mental Health in England, 2005) was released; the document detailed how psychiatrists could provide better person centred care for service users. In 2007, New Ways of Working for Everyone (NWW, DoH, 2007b) was published; this document included the same aim of promoting better care for service users but took a wider focus of developing change nationally across staffing groups. For example, new roles such as Primary Mental Health Care Workers introduced more healthcare support at different levels of services. A Creating Capable Teams Approach (CCTA) supported teams in developing their workforce to meet the proposals of the NWW documents and meet service user need. NWW (DoH, 2007b) proposed a shift in the structure and organisation of mental health services. There are significant pressures on staff in the NHS to continually evolve to provide a more efficient, effective service and while changes can be positive they can also lead to difficulties. Some theories of organisational change have been proposed to explain the processes involved in changes to organisations.

Multiple theories have been developed in an attempt to understand the complex processes involved in change in organisations. These change theories have been reviewed in depth elsewhere (By, 2007; Barnard & Stoll, 2010). One of the earliest but still widely used theories of organisational change is Lewin's (1952) planned theory of change. Lewin (1952) proposed three stages to an organisational change: unfreeze the organisation's present state; make the desired change; refreeze the organisation in new desired state. If the organisation does not take active steps to refreeze change, then resistance to the change from staff can lead to a return to the previous ways of working. Emergent theories of change offer an alternative to planned change theories. In emergent theories, change is a continuous process without time constraints and a fixed end-point, change is viewed as unpredictable rather than planned (By, 2007). Emergent theories include steps that those in management in organisations can use as a guideline to

facilitate change. One influential example of this is Kotter's (1995) 'Eight Stage Process for Successful Organisational Transformation'. (See Table 1)

Table 1: Kotter (1995) Eight Stage Process for Successful Organisational Transformation

(1) establish a sense of urgency about the need to achieve change – people will not change if they cannot see the need to do so;
(2) create a guiding coalition – assemble a group with power energy and influence in the organization to lead the change;
(3) develop a vision and strategy – create a vision of what the change is about, tell people why the change is needed and how it will be achieved;
(4) communicate the change vision – tell people, in every possible way and at every opportunity, about the why, what and how of the changes;
(5) empower broad-based action – involve people in the change effort, get people to think about the changes and how to achieve them rather than thinking about why they do not like the changes and how to stop them;
(6) generate short-term wins – seeing the changes happening and working and recognizing the work being done by people towards achieving the change is critical;
(7) consolidate gains and produce more change – create momentum for change by building on successes in the change, invigorate people through the changes, develop people as change agents; and
(8) anchor new approaches in the corporate culture – this is critical to long-term success and institutionalizing the changes. Failure to do so may mean that changes achieved through hard work and effort slip away with people's tendency to revert to the old and comfortable ways of doing things.

Kotter's (1996) model remains popular, but the stages do not account for the role of change agents in the organisations (Burnes, 2009). Both the stage and emergent models of change provide frameworks for understanding change in organisations, however, the role of emotional processes is not acknowledged.

Some theorists offer explanations of the psychological difficulties of change, in particular, Rousseau's (1989) Psychological Contracts and Kubler-Ross (1973) Stages of Grief Reaction. Rousseau (1989) proposes that unwritten contracts are present between employers and employees that contain individual beliefs about the reciprocal obligations that both parties have to each other. Due to the unwritten and subjective nature of the contracts, each party can have different ideas about the responsibilities of the other. When organisations change, these contracts may need to be renegotiated as roles and expectations shift. Kubler-Ross (1973) identified five stages of grief that individuals go through in response to a loss (denial, anger, bargaining, depression and acceptance). By using these theories to understand the grief response of staff during organisational change, those managing the change can offer emotional as well as practical support to staff (Bell & Taylor, 2011).

The range of theories applied to explain organisational change reflects the complexity of the processes involved. As organisational change within mental health services is such a frequent occurrence, it is important to evaluate how staff are supported to implement and maintain these changes. This review aims to explore how staff in NHS mental health services experience organisational change and what helps staff in NHS mental health services to adapt to organisational change.

Methodology

As the publication of New Ways of Working for Everyone (DoH, 2007b) proposed significant changes to how mental health services were delivered this date was used at the starting point for literature to be reviewed focussing on organisational changes to NHS mental health services in the UK. Whilst it could have been interesting to compare the results from international studies to those from the UK it was beyond the scope of this review.

Search Terms

The search terms for the review were: ‘Mental Health Services’ AND ‘Organizational Change’ OR ‘Organisational Change’. The literature search was conducted between 3rd September 2014 and 15th January 2015. The databases included in the search were HDAS and EBSCO. Within HDAS, HMIC, Embase and Health Business Elite were included. The databases included in the EBSCO search were: AMED, Medline, Psycinfo, Sport Discuss, Ageline, Cinahl Plus, Academic Search Complete and Psycinfo. When the search terms were applied to the two databases indicated with the date range of 2007-present, HDAS delivered 162 and EBSCO 1448, providing a total of 1610 studies with duplicates removed. Studies that were not from the United Kingdom were excluded, providing 158 studies in total from the two databases. The abstracts of the 158 studies were reviewed and studies that did not focus on mental health services or an organisational change were removed providing 81 studies. Removal of non-exact duplicates removed a further 6 studies. The remaining 75 studies were reviewed and studies were only included if the focus was an actual organisational change, exploration of staff experiences and a mental health service. This left 9 studies for the final review (See Table 2). These studies involved three types of changes: changes to organisational structure, implementation of a protocol/programme and change in response to government guidelines. The results of the studies were subject to a theoretical thematic analysis.

Search Strategy: Figure 1

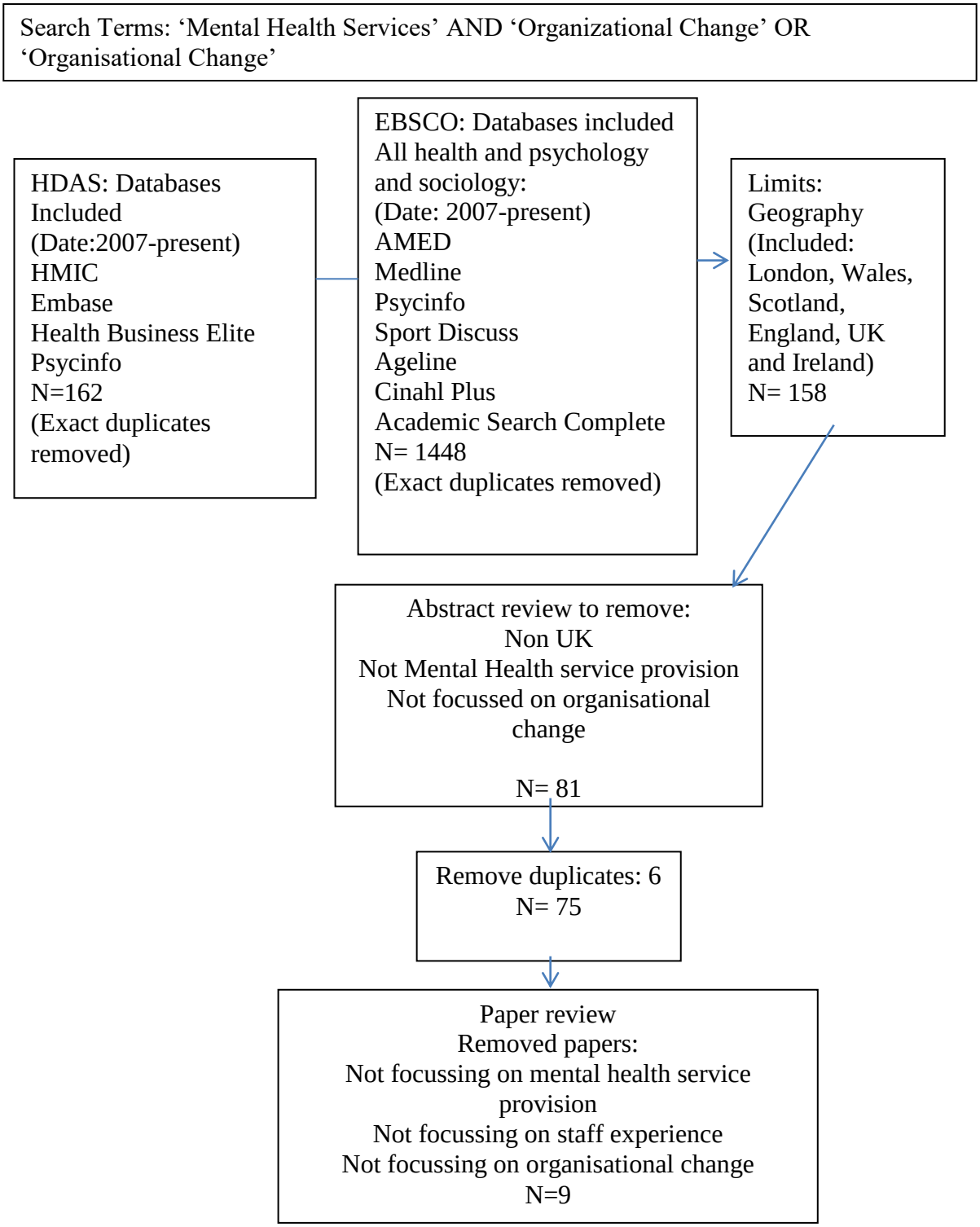


Table 2: Papers Reviewed

Author	Title	Design	Key Results	CASP	
				Positives	Negatives
Astbury, G. et al (2011)	Cultural change in a learning disability secure service: the role of the 'toggle' group	Focus Groups Staff members	Group dynamics important - positive, negative and 'toggle' group that switch dependent upon several factors.	Justify methodology Sampling justified with limitations considered Embedded themes Further research identified Transferability discussed	Self-selection in recruitment
Baker, J., Playle, J., Nelson, P. and Lovell, K. (2010)	An evaluation of the impact of the recommendations of the Chief Nursing Officer's (England) Review of Mental Health Nursing in Mental Health Trusts and Universities in England: Findings from Stage One, an e-survey	E-Survey: closed and open questions NHS Trusts Universities	Competing priorities and engagement with too many initiatives can reduce engagement with changes. Organisational engagement with changes key	Implications for practice highlighted Results linked to literature and government guidelines	Limitations to use of E-survey, such as sampling bias, these are discussed
Dickinson, H., Peck, E., Davidson, D. (2007)	Opportunity seized or missed? A case study of leadership and organizational change in the creation of a care trust	Action Research: Semi-structured interviews Service Users, Carers, Staff, Management	Long history of health and social care services working together. Too much consensus can inhibit innovation. Leadership and communication important	Methodology justified Thorough review of background literature	No explicit research question Little description of recruitment or analysis No embedding of themes
Evans, N.	Improving the timeliness	Action	Action research support	Ethical issues detailed,	

(2014)	of mental health assessment for children and adolescents in a multidisciplinary team	Research: Postal questionnaires, semi-structured interviews, collaborating staff team Service Users, MDT	change by engaging staff	including impact of researcher being a clinician Multiple data sources used	
Greenwood, Paul (2007)	Supporting Change: implementing New ways of working in East Lancashire	Interviews Staff Service users Carers	Communication between teams to encourage MDT approach, more negative views expressed in a group, IT systems should be fit for purpose.	Aims linked to relevant documents	Limited recruitment information No ethical issues, limitations or further research discussed
Kelly, M., Humphrey, C. (2013)	Implementation of the care programme approach across health and social services for dual diagnosis clients	Case study: Framework analysis Staff Carer and service user reps	Difficulties where change across two different services, contextual factors affected change and targets can increase uptake.	Multiple data sources to make more rigorous Results linked to existing research Implications considered	Insufficient detail on method for replication No further research identified
Khandaker, G., Cherukuru, S., Dibben, C., Ray, M.K. (2009)	From a sector-based service model to a functional one: Qualitative study of staff perceptions	Semi-structured interviews Staff	Staff have positive and negative thoughts about change, significant concerns on impact of patient care and caseloads. Communication key solution	Sampling, collection and analysis clearly described and appropriate Influence of researcher considered with attempts to minimise bias	Limited detail on ethical issues

				(triangulation)	
Lewis, A., Ilot, I, Lekka, C., Oluboyede, Y. (2011)	Improving the quality of perinatal mental health: a health-visitor led protocol	Case Study: Semi-structured interviews, focus groups, non-participant observations Service Users Staff	Key staff as drivers, responsive to local need, continuity of clinical and operational leadership	Design justified Some quotes included in results Implications for practice locally and nationally considered	No service user validation, but this is acknowledged No discussion of relationship of researcher to participants
Riley, A.J., Bing, R., White, C., Smith, S. (2008)	Utilising theories of change to understand the engagement of general practitioners in service improvement: a formative evaluation of the Lewisham Depression Programme	Questionnaires GP Surgeries	Variety of organisational factors influence engagement with the programme such as communication from manager and meeting with facilitators of programme.	Recruitment procedures clear with attempts at matching groups Implications for practice detailed	Limited discussion of ethics No future research identified

Critical Appraisal of Studies Reviewed

The studies selected for the review were categorised into three areas based on the type of change in the study: change to organisational structure; implementation of a protocol or programme and change following government guidelines. A brief description of each study is provided along with salient evaluation points highlighted from the Critical Appraisal Skills Programme (CASP, 2013, see table 2) which was adapted to evaluate the selected studies. Six of the studies reviewed were qualitative and three used a mixed methodology, which reflected the focus on the experiences of those involved in the change and the complexity of studying the processes involved in change. It was the differences in methodology that required the adaptation of the CASP as the questions specific to qualitative methodology were not always relevant to the quantitative studies.

Change to Organisational Structure

Dickinson, Peck and Davidson (2007) and Astbury et al (2011) undertook research investigating changes to organisation structures. Dickinson et al (2007) reported on a partnership between a mental health NHS trust and a social care trust. Positive factors identified following change were the smooth transfer of staff from local authority to the NHS, joint systems procedures and policies and prompt decision-making. Maintaining positive practices was viewed as important whilst remaining open to new opportunities. However, the maintenance of the old culture was viewed as limiting innovation. The authors concluded that the merger had made little difference to staff working practices due to working closely with mental health and social services prior to change. The methodology was justified in relation to the study area and provided a good example of the application of an action research approach; however, there was little description on recruitment to the study, data analysis or credibility of the findings. There was a thorough review of background literature from private sector studies, which while useful in providing context to the study left limited space to discuss the findings from the study itself.

Astbury et al (2011) explored group dynamics during the change of a learning disability secure service making the transition from medium to low security. Three groups were identified through focus groups with staff from psychology, nursing,

social work and occupational therapy. One group was positive and dynamic in response to change, a second was resistant to change and strategic in how they opposed change and the third group was a ‘toggle’ group that would shift allegiance depending on the circumstances. The presence of one dominant individual influenced the toggle group. Staff in the positive and resistant groups saw the toggle group members as switching positions and offering little resistance to change. A range of short and long-term strategies were identified which influenced the toggle group: these included offering praise and improved relations with patients and staff, and the promotion of a new identity through cultural change. Change processes were supported by effective communication and reducing uncertainty. The study usefully identified that different groups can form in response to their reaction to change, with suggestions as to how to influence a group without clear feelings towards the change. This has implications for understanding how to secure support through organisational change. The sampling method is justified in the same way with an acknowledgement of some of the limitations of allowing some self-selection. The data collection method is explicit and the coding method is clearly detailed with quotations to embed themes in the data.

Implementation of a Protocol or Programme

Studies by Riley, Byng, White and Smith (2008), Evans (2014) and Lewis, Ilott, Lekka and Oluboyede (2011) explored the change process in response to the implementation of a protocol or programme. Riley et al (2008) aimed to evaluate engagement with a programme developed by Lewisham Primary Care Trust (PCT) designed to engage General Practitioners (GP’s) and nurses working in medical practices in working with clients labelled as having depression. The study utilised theories of change and ethnography to design questionnaires to send to staff at GP practices. Four areas linked to involvement in the programme: personal beliefs about quality improvements and depression, practice contextual factors, program related factors and the wider context. Personal beliefs about quality improvement and depression involved viewing audit as a useful tool or as a way of improving care for service users with depression and lacking confidence in managing patients. Practice contextual factors were good working relationships with colleagues, involvement in other quality improvement initiatives, the practice of

allowing time for improvement activity and prioritising mental health issues. Having some knowledge and understanding of the program influenced involvement in the audit; other program related factors involved the facilitators meeting with the practice staff, and the practice manager supporting the program. The wider context related to positive relationships with clinical governance projects and the primary care trust. Disincentives to involvement included lack of time, inadequate staffing, multiple initiatives and the practice already prioritising mental health; common difficulties facing those working in mental health services.

Recruitment procedures were clear with attempts made to match the engaged and not-engaged groups. Links were made between the results and the aims of the research. No future research was identified but implications for practice and delivery of programmes were discussed.

Evans (2014) used an action research approach to improve mental health assessment for children and adolescents in a multidisciplinary team (MDT). A project was developed to create a bespoke initial assessment procedure for the service using an action research approach to engage staff and ensure the assessment was fit for purpose. The use of a multidisciplinary team to collaborate on the project led to greater understanding across professions, team belonging, enhanced working relationships and shared knowledge. Action research as a key to engaging staff with organisational change is highlighted and supported by existing research. The ethical difficulties which led to the omission of particular service users is acknowledged as well as the ethical dilemmas facing the researcher when acting as both a researcher and a clinician within the service.

Lewis et al (2011) reported on the development of a protocol to improve perinatal mental healthcare. A case study method explored the factors associated with successful implementation of the protocol. Interestingly, engagement with the development of the protocol led to feelings of ownership and pride; this increased motivation to implement the strategy. Senior team members provided strategic support to enhance multidisciplinary, inter-agency and user involvement. Maternal mental health problems were a priority for the service and so management prioritised this area by allowing staff time to contribute to the project and funding training. Factors associated with success of the protocol included staff viewing it

as an evidence-based tool, being able to use it flexibly in response to service user need and allowing for consistency of interventions. Organisational factors that supported the project included continuity of clinical management leadership throughout the development, implementation and evaluation phases of the protocol. In terms of evaluation, there is no discussion of whether the researchers' had worked with the participants as this could have caused participants to feel under pressure to participate. Implications for practice locally and for the NHS in general were identified with links made to other research.

Change in Response to Government Guidelines

Studies by Baker, Playle, Nelson and Lovell (2010), Greenwood, Ryan, Keaveny and Deo (2007), Khandaker et al (2009) and Kelly and Humphrey (2013) involved change following the publication of government guidelines. Baker et al (2010) evaluated the impact of the recommendations of the Chief Nursing Officer's (CNO) review of mental health nursing in both mental health trusts and universities using an e-survey. Trusts were identified from Department of Health and Health Care Commissioning Databases. The universities were identified as offering pre-registration mental health nursing courses in England from the Nursing and Midwifery Admissions Service and the University and College Admissions Service databases. Forty-two mental health Trusts completed the survey, ranking their progress on the recommendations made in the chief nursing officer's report. Participating institutions also indicated what they considered to be the facilitators and barriers to progress. Quantitative data was analysed using descriptive statistics and qualitative information was analysed with thematic content analysis. The biggest facilitators for Trusts were the organisation engaging with the recommendations and links with other national policy initiatives, such as the Standards for Better Health Framework. For the universities, joint working within and outside of the organisation and having input from service users and carers were the top two facilitators. Barriers to implementing the recommendations included experiencing competing priorities, lack of funding and a lack of ownership outside the nursing profession. The study justified the use of an E-survey in relation to the aims of the study and the chance to survey a wide range of people. The potential limitations of this methodology were discussed and steps identified to minimise the impact of these.

Greenwood et al (2007) described supporting change in adult mental health services following New Ways of Working for Psychiatrists (Department of Health et al, 2005). This document recommended psychiatrists worked in either inpatient or community services. Interviews with consultants and service users and carer identified existing practice and current issues. Following the feedback from the interviews, changes were made to both inpatient and community services such as psychiatrists in inpatient services psychiatrists being assigned to working on one ward, and in the community a community services governance group supported developments in practice. The biggest barrier to change implementation was the view that the service operated adequately already. Groups of professionals expressed more negative views about change than individuals did. This shows the role of staff member attitudes in facilitation of smooth organisational change and the impact of group dynamics. Information technology systems being unfit for purpose increased negative views about change. The overall outcomes of the change were better understanding between teams and professions, a solution focused approach to multi-disciplinary discussions, improved multidisciplinary working between services and improved service user and carer feedback within inpatient services. The main reason for the success of the change was openness to working differently and good communication between teams. Interviews were a suitable methodology for gathering both service user and staff perspectives; however, it is unclear how the data gathered was analysed. There was no consideration of ethical issues, limitations of the study or areas for further research.

Khandaker et al (2009) also focused on the implementation of changes as a result of New Ways of Working for Psychiatrists (DoH et al, 2005). The study assessed staff perceptions of the changes in an adult mental health service. Semi-structured interviews were conducted with staff from inpatient units, community mental health teams and specialist teams such as the home treatment team. Twenty-one staff members were interviewed and the sample comprised consultant psychiatrists, trainee doctors, team leaders and managers, senior nurses, social workers, support treatment and recovery workers, psychologists and occupational therapists. Staff expressed concerns about the impact of the changes on care, limited consultation over the changes and confusion about reasons for the change.

The solution to concerns was improved communication, for example, jointly agreed care plans and attending other teams' meetings and clear guidelines for teams on their responsibilities. Staff identified the need for evaluation of the system at a later stage. The importance of involving staff members of the organisation throughout the change process supported feelings of ownership and increasing commitment. Communication had the impact of countering rumours starting as a result of a lack of information. Change caused stress and potentially problems with recruitment and retention, with communication between staff and management highlighted as a solution. Clear communication from management through the change period was important in facilitating change for staff. Whilst communication was recognised as a key facilitator, the type of communication that is beneficial is not. The goals and aims of the study were clear and linked to local and national policy change in mental health services. The methods of sampling, data collection and data analysis are described and the influence of the researchers is considered with details of attempts made to minimise bias such as using standardised interviewing techniques.

Kelly and Humphrey (2013) explored the implementation of the care programme approach (CPA) for clients with mental health problems and intellectual disability in a mental health foundation trust using a case study approach, interviewing key staff and stakeholders. The aim was to understand the strategy for implementing CPA within a trust, as well as collecting information on progress. A review of organisational change and partnership working literature identified themes to develop a framework to analyse the data. The data gathered from the study was processed through the framework to identify themes. Six key organisational level factors were identified that influenced progress: organisational complexity; complex governance and accountability arrangements; competing priorities; financial constraints; high staff turnover; complex information and IT systems. Five challenges specific to the locality studied were: lack of education and training; inability to engage staff and key people; conflict in traditional professional roles and cultures; the absence of a joint vision, understanding and commitment; the absence of shared strategies and policies. The paper includes a description of the framework approach to analysis of the data but this was not sufficient to be replicable. Links are made between the findings and existing research and the

wider implications of the findings cited, though suggestions for further research could have been included to build on the findings of this paper.

The studies selected provide a variety of perspectives on the experiences of staff in organisations undergoing change. Despite the qualitative nature of the study designs, there was often limited reflexivity about the impact the researchers have on the data. This is surprising, as even when the researcher is not part of the organisation under scrutiny it is likely they will have their own assumptions about and experiences of change. This could influence the way the researcher selects themes and interacts with participants.

Results of the Thematic Analysis

The findings of the studies were analysed using theoretical thematic analysis (Braun and Clarke, 2006) to identify overall themes in the data. The generation of themes was linked to the specific research aim to identify how staff experience change and what helps in the change process. The studies reviewed focused on staff experiences and as a result were predominantly qualitative. As such, thematic analysis offered a method of analysis of descriptive results. Each paper was read and the results of the studies along with any participant quotes presented were coded. Patterns in the coding across the data set were identified and collated into themes and sub themes (Braun and Clarke, 2006). The themes identified were: method of change, organisational factors and communication and relationships (Table 3).

Table 3: Results of thematic analysis

Theme	Codes	Explanation
Method of change	Using evidence	Implementing change as a result of evidence
	Context	Factors influencing the organisation
	Incentives	Targets or rewards for change
Organisational Factors	Developing strategy	A clear, cohesive plan
	Resources	Adequate resources to enable change
	Culture	Balancing maintenance of positive existing culture with new opportunities
Communication and Relationships	Consultation	A variety of stakeholders
	Team working	Communication and cooperation between teams
	Consistency	Consistent messages
	Relationship-communication links	Good communication across relationships increases trust and helps to manage resistance and ambivalence
	Key figures	Informed leaders and staff to initiate and monitor change

Method of change

The method of change was highlighted in several papers. Evans (2014) recognised the benefits of using an action research approach to engage staff in change and encourage discussion and collaboration. The action research methodology allowed for simultaneous implementation and analysis of the change. A team member as a researcher supports the credibility of the change (Evans, 2014). Lewis et al (2011) reflect on the role of the multi-disciplinary and multi-agency approach as having increased engagement with and integrity of the changes. Consideration is also given to the work undertaken before the change is initiated. Both Lewis et al (2011) and Evans (2014) advocate the use of a thorough review of evidence in the area of the proposed change to support the value of healthcare professionals that practice should be based on evidence and so is congruent with their practice. This had the added benefit of engaging senior levels of management with the process and legitimised the changes proposed. The context surrounding the changes is also a key consideration. Dickinson et al (2007) and Riley et al (2008) viewed positive relationships with other organisations, such as clinical governance projects, as increasing interest in the change as it increased cohesiveness with existing projects and cultures. Success of proposed changes was associated with links to existing quality improvement initiatives without feeling there are too many, changes to service are viewed as consistent rather than splitting resources to achieve conflicting goals (Riley et al, 2008, Baker et al, 2010). Unsurprisingly, staff attitudes towards change can influence the success of a change. Success factors include viewing the change as beneficial to the care of service users (Riley et al, 2008, Astbury et al, 2011 and Khandaker et al, 2009), responsive to local need (Lewis et al, 2011), improving training (Khandaker et al, 2009) and confidence (Riley et al, 2008) and clearer care pathways (Astbury et al, 2011). The use of targets and penalties related to uptake of particular procedures can increase change implementation, but caution should be used as they can lead to a reduced focus on non-targeted areas (Kelly and Humphrey, 2013). When considering the implication of these findings it illustrates that careful consideration as to how changes are selected, who is involved in identifying them and the methodology used to develop and implement the changes are important for success. If these factors are taken into account in a

way that is suitable for the organisation it can strongly influence the attitudes towards change that may be more difficult to affect later in the change process.

Organisational Factors

A variety of organisational factors can potentially increase the chances of successful change. One of the suggested factors is to incorporate the change into an overall improvement strategy for the service, rather than an addition to the workload (Riley et al, 2008, Baker et al, 2008). To facilitate this, clear guidelines on how the change can be implemented could be produced, locally (Khandaker et al, 2009) or nationally (Kelly and Humphrey, 2013), to provide continuity in service user care and implementation of the changes. Other ways to promote change within a service are to allow time for implementing and evaluating the change (Riley et al, 2008); this could demonstrate management support for the change. Incorporating the change duties into job descriptions can prevent apathy and a lack of commitment (Kelly and Humphrey, 2013, Astbury et al, 2011). Consistency within the organisation can stabilise the change process by maintaining organisational memory and maintaining key staff to drive forward change (Lewis et al, 2011). Stability of leadership is also important from both an operational and clinical perspective to maintain the focus of the change while other organisational shifts are occurring (Lewis et al, 2011). The culture of the organisation is also subject to analysis, particularly where change is at an organisational level, namely service mergers. Maintaining the old culture of services can increase the chances of a smooth transition. However, maintaining too much of the old culture can lead to a lack of innovation that misses new ways of working (Dickinson et al, 2007). Ensuring key factors are available to support the change can help to establish a positive relationship with the changes and increase staff confidence in their ability to implement change. These factors include the quality of the evidence for change (Greenwood et al, 2007), financial resources (Baker et al, 2010), sufficient staffing levels (Riley et al, 2008) education and training (Kelly and Humphrey, 2013) and adequate Information Technology systems (Greenwood et al, 2007, Kelly and Humphrey, 2013). These strategies offer practical approaches that can increase the chances of a successful change.

Communication and Relationships

Communication is influential in the success of organisational change. When deciding upon changes, consultation at different levels of the organisation is beneficial and should focus on service users (Greenwood et al, 2007, Kelly and Humphrey, 2013, Lewis et al, 2011). Consultation should also include a variety of stakeholders at different levels of the organisations involved (Khandaker et al, 2009) to promote discussion, consultation and feedback (Baker et al, 2010). Promoting communication between teams involved in changes can reduce professional or historical divisions and lead to an increase in trust and cooperative MDT working (Khandaker et al, 2009, Greenwood et al, 2007). This can have the additional effect of creating opportunities for training and supervision across professions (Evans, 2014). Communication and consultation increases feelings of ownership and commitment (Khandaker et al, 2009, Lewis et al, 2011). This can reduce uncertainty about the change by clarifying the future direction of the service, which in turn can lessen the stress caused by the changes (Astbury et al, 2011). The communication of management to frontline staff regarding the change should also offer consistent messages (Dickinson et al, 2007) that address the concerns held by staff (Astbury et al, 2011). This can reduce counter communication and rumours that increase uncertainty, and potentially reduce staff attrition throughout the changes and avoid the cost and difficulty of recruiting for new positions (Khandaker et al, 2009). Positive relationships are also linked to communication. Good working relationships with colleagues (Riley et al, 2008), management (Baker et al, 2008) and wider organisations/partners (Dickinson et al, 2007) increase the chance of a smooth change. This can increase feelings of trust and reinforce good communication pathways. More specifically, when establishing change, meeting with those the change will affect can be helpful (Riley et al, 2008). Consideration of the different relationships within a staffing group can help to identify ways to manage positions of resistance or ambivalence to change (Astbury et al, 2011). Identifying charismatic and well-informed leaders and champions can increase positivity towards change in ambivalent staff members as well as providing key staff to monitor and support change (Kelly and Humphrey, 2013).

The studies reviewed illustrate the potential difficulties faced by those implementing and those experiencing change. The barriers and facilitators to the changes implemented in the studies reviewed cover the three areas of: method of change, organisational factors and communication and relationships. From this ways to support and maintain changes within UK, mental health organisations have been identified.

Discussion of the findings

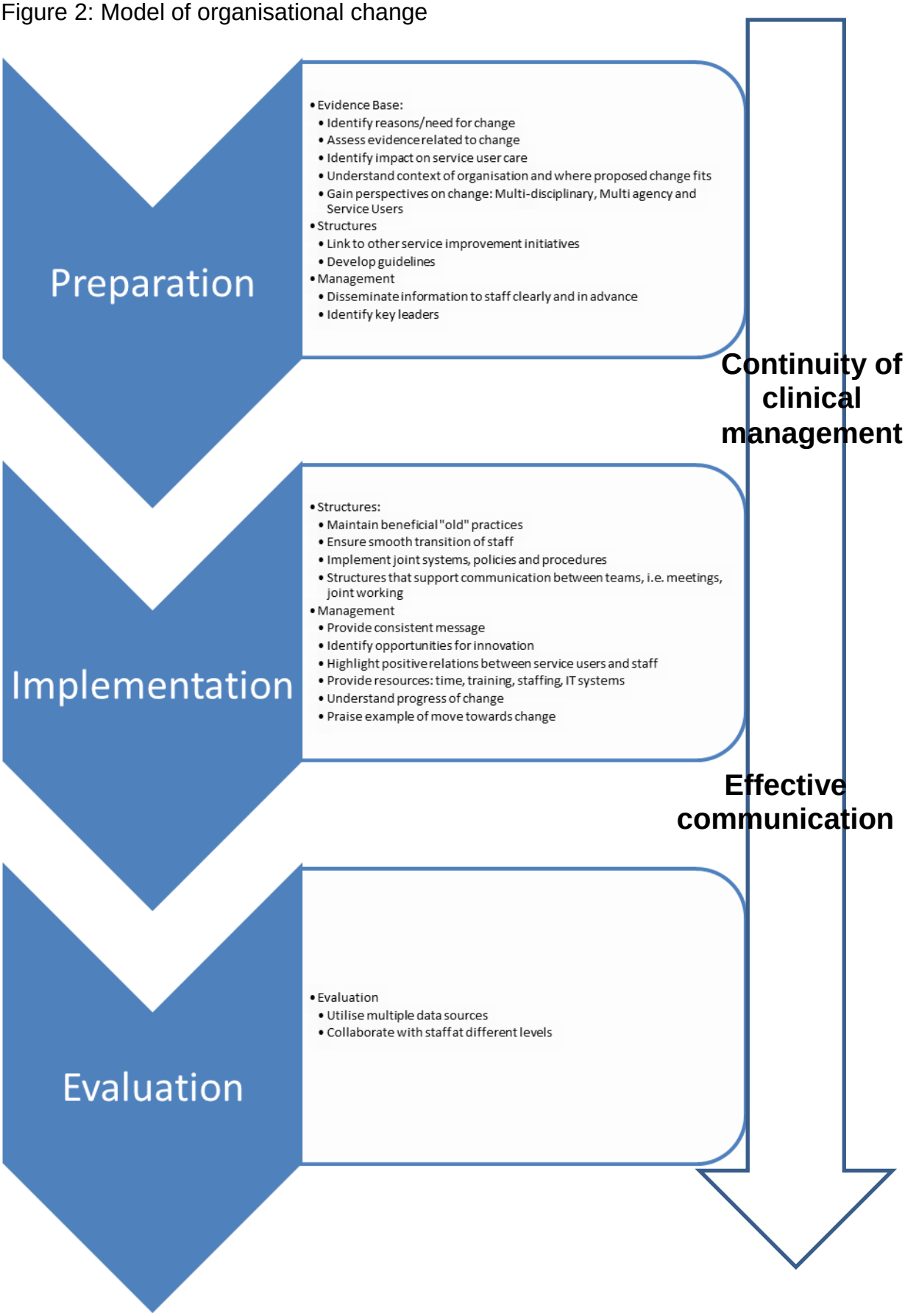
The findings from the review suggest that there are strategies that can be implemented by those structuring and leading change in organisations to increase the chances of change being successful. These include considering the method of change, ensuring the organisation can support the change, and maintaining clear communication and supportive relationships with staff as well as with any partner organisations. However, the papers selected for the review do not link the changes to theories of organisational change, this is important because the analysis highlights that change should be evidence based. Riley et al (2008) discussed developing theories of change naturalistically through the implementation of the programme but did not link the findings to existing change theories. When reviewing the papers in light of Lewin's (1952) theory, there are strategies that are similar to the unfreezing and changing stages but there was no discussion related to refreezing the organisation. If organisations take steps to refreeze the organisation, the resistance to the changes can be better managed. In the papers reviewed, there is no follow up information included so it is unknown whether the changes to the organisations were maintained. Tasks similar to those detailed in Kotter's (1996) model of change tasks are described, such as communication to manage barriers to change and the need to engage key staff in the change, but there were no explicit links. The exploration of the psychological experiences of staff undergoing change is limited to stress. The studies do not include exploration of psychological processes, therefore there is limited guidance on how to best support staff through the psychological difficulties changes can pose such as the grief reaction hypothesized by Kubler-Ross (1973). None of the authors of the studies integrated the theoretical models with the findings from the study and while

they suggest how to support staff through change there is a lack of a cohesive approach.

Model of organisational change

Following the thematic analysis, the information from the studies regarding what helps and hinders staff adapt to the process of change in mental health services in the UK was further synthesised and incorporated with the stage and emergent models of change. This allowed the key factors to be identified and developed into a model for supporting change (see figure 2).

Figure 2: Model of organisational change



The model identifies three stages to managing organisational change: preparation, implementation and evaluation. Throughout the change process, ensuring clear communication and continuity of clinical management should aim to be maintained. Communication can reduce uncertainty and support engagement and implementation. Continuity of clinical management helps to maintain organisational memory and support continuity of communication and resources. The model considers the stages proposed by Lewin's (1952) model and includes the refreezing aspect of the model whilst proposing some similar strategies to Kotter's (1996) emergent model of change. Due to the lack of research on the psychological processes experienced during organisational change in mental health services, this has not been included in this model.

Preparation

The preparation stage involves identification and dissemination of evidence regarding the change, understanding the impact on the structures of the organisation, making links to other service improvement initiatives and identification of key leaders. Clearly communicating evidence can increase staff confidence in the change. Where possible the review of the evidence should involve both professionals and service users to promote engagement and take account of multiple perspectives. Disseminating information widely reduces reliance on rumours that can generate anxiety in staff. Linking the change with other initiatives streamlines the changes with the overall direction of the service and avoids staff feeling bombarded by changes. Key leaders should be well informed and influential to increase consistency in the message delivered and engender feelings of trust.

Implementation

The implementation stage involves continuing to understand the structure and role of management. Maintaining some original practices can help staff to feel secure by reducing the chances they feel overwhelmed. In addition, any staff transitions should be as smooth as possible to reduce uncertainty. Joint systems, policies and procedures between teams and/or services can support consistent transitions where teams are merging. Applying joint working can reduce feelings of one service or team taking over another that could lead to divisions in the team based

on historical membership. Ensuring structures support communication, for example joint working, can further help to reduce historical divisions by promoting better understanding of the roles and responsibilities of different groups.

Management should provide consistent messages to decrease feelings of uncertainty. Aiming for a balance between innovation and stability can ensure that new ways of working are identified without staff feeling uncertain of their roles. Management should provide adequate resources to facilitate the change. These should include time, training, levels of staffing and IT systems. This can reduce stress in staff and shows organisational commitment. Providing clear guidelines can support consistency and reduce uncertainty.

Evaluation

Evaluation enables assessment of the change and can identify further changes or adaptations. Evaluation should include multiple data sources to increase validity of the findings and engage with different levels of the organisation to capture a range of responses.

Limitations of the Review

In terms of limitations of the review, unpublished studies were not included in the research. Due to publication bias, studies that did not find results could have been missed and consequently omitted findings relevant to the review question. However, it was beyond the scope of this review to include unpublished papers. Only studies from the UK were included. The rationale that the service structure and cultures may be different internationally stands; however, in some regions, the structure of mental health services may have been similar enough to allow comparison. Studies were included if the primary focus was on NHS mental health services or an NHS service that provided mental health support as part of the service remit. This meant studies that focussed on services related to mental health service users but not directly involved in mental health care, such as employment services, or private and voluntary services were not included. There may be similarities in the factors associated with change in these other services but it was beyond the scope of this review to include these.

Implications and Future Research

The review has identified a variety of factors that can facilitate change in NHS services providing mental healthcare in the UK. By better understanding how to support staff before and during changes to services, the process of change can be smoother and more effective. There could also be a reduction in the financial implications of changes, such as in the case of change that has not been planned appropriately, staff attrition and loss of partner relationships. The NHS is a complex organisation comprised of various sub organisations in the form of NHS Trusts and services commissioned to be run by private and voluntary companies. They are also subject to implementation of policies by various government bodies such as DoH and NICE. As such, it is not surprising that change is a common occurrence. With change identified as a challenging process, any advances on understanding managing change should have a positive impact on the service, staff and service users. A further review could identify the impact of organisational change in mental health services on service users. In addition, a review of studies engaging service users and carers in organisational change could yield information on best practice in engaging service users and carers in organisational change and the impact of this on the service and the staff.

This review has focussed on research since the publication of NWW for everyone (DoH, 2007b). Further reviews could look at earlier papers and consider whether the release of NWW influenced organisational change in the NHS (DoH, 2007b). The focus here was also on the impact of change on the organisation and the staff involved a review of service users' experiences of organisational change could provide an understanding of how best to support service users during change.

Conclusion

When reviewing papers since NWW (DoH, 2007b) there are a variety of changes occurring in a range of services providing mental health care. As change is a difficult process it is useful to identify common factors that can improve the change process, for example, clear communication in advance of a change and ensuring staff consultation in the development of changes to services. More research in the form of quantitative testing of specific strategies would develop this area; however, due to the variety of services, range of changes and the current lack of agreement

on specifically what works, more research would need to be done to facilitate this. The review has only focussed on staff and further reviews could consider the service user experience of organisational change. The papers identified provide a useful starting point for understanding how leaders and managers in mental health organisations can support staff through change. It could also help with identification of those staff members with the combination of training, values and skills to lead services through change.

References

Appelbaum, S. H., Habashy, S., Jean-Luc Malo, & Shafiq, H. (2012). Back to the future: Revisiting kotter's 1996 change model. *Journal of Management Development, 31*(8), 764-782. doi:10.1108/02621711211253231

Astbury, G., Lovell, A., Mason, T., & Froom, K. (2011). Cultural change in a learning disability secure service: The role of the 'toggle' group. *Journal of Psychiatric & Mental Health Nursing, 18*(9), 804-812. doi:10.1111/j.1365-2850.2011.01725.x

Baker, J., Playle, J., Nelson, P., & Lovell, K. (2010). An evaluation of the impact of the recommendations of the chief nursing Officer's (England) review of mental health nursing in mental health trusts and universities in England: Findings from stage one, an e-survey. *Journal of Clinical Nursing, 19*(17), 2590-2600. doi:10.1111/j.1365-2702.2009.03105.x

Barnard, Matt & Stoll, Naomi & Centre for Understanding Behaviour Change (University of Bristol) (2010).*Organisational change management a rapid literature review*. Centre for Understanding Behaviour Change, Bristol

Bell, E., & Taylor, S. (2011). Beyond letting go and moving on: New perspectives on organizational death, loss and grief. *Scandinavian Journal of Management*, 27(1), 1-10. doi:http://dx.doi.org.ezproxy.staffs.ac.uk/10.1016/j.scaman.2010.09.013

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Burnes, B. (2009). *Managing change: A strategic approach to organizational dynamics*. Harlow: Financial Times Prentice Hall.

Critical Appraisal Skills Programme. (2013). Qualitative research: Appraisal tool. 10 questions to help you make sense of qualitative research. Retrieved from http://media.wix.com/ugd/dded87_951541699e9edc71ce66c9bac4734c69.pdf

Department of Health (2007b) *Mental Health: New ways of working for everyone, Progress report*. Department of Health: London.

Department of Health, Royal College of Psychiatrists and National Institute for Mental Health in England (2005) *New Ways of Working for Psychiatrists.* London: Department of Health.

Dickinson, H., Peck, E., & Davidson, D. (2007). Opportunity seized or missed? a case study of leadership and organizational change in the creation of a care trust. *Journal of Interprofessional Care, 21*(5), 503-513.

Evans, N. (2014). Improving the timeliness of mental health assessment for children and adolescents in a multidisciplinary team. *International Practice Development Journal, 4*(1), 1-13.

Greenwood, P., Ryan, T., Keaveny, J., & Deo, R. (2007). Supporting change: Implementing new ways of working in east Lancashire. *Mental Health Review Journal, 12*(3), 10-14.

Ham, C. (2014). Reforming the NHS from within. *Beyond hierarchy, inspection and markets,* Kings Fund: London.

Jones, G. R. (2013). *Organizational theory, design, and change*. London: Pearson.

Kelly, M., & Humphrey, C. (2013). Implementation of the care programme approach across health and social services for dual diagnosis clients. *Journal of Intellectual Disabilities, 17*(4), 314-328. doi:10.1177/1744629513508383

Khandaker, G., Cherukuru, S., Dibben, C., & Ray, M. K. (2009). From a sector-based service model to a functional one: Qualitative study of staff perceptions. *Psychiatric Bulletin, 33*(9), 329-332.

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. (cover story). *Harvard Business Review, 73*(2), 59-67.

Kubler-Ross, E. (1973). *On Death and Dying.* Retrieved from http://www.ebrary.com

Lewin, K., & Cartwright, D. (1952). *Field theory in social science: Selected theoretical papers* London: Tavistock

Lewis, A., Ilott, I., Lekka, C., & Oluboyede, Y. (2011). Improving the quality of perinatal mental health: A health visitor-led protocol. *Community Practitioner, 84*(2), 27-31.

Riley, A. J., Byng, R., White, C., & Smith, S. (2008). Utilising theories of change to understand the engagement of general practitioners in service improvement: A formative evaluation of the Lewisham depression programme. *Quality in Primary Care, 16*(1), 17-26.

Rousseau, D. M. (1989). Psychological and implied contracts in organizations. *Employee Responsibilities & Rights Journal, 2*(2), 121-139.

Todnem By, R. (2005). Organisational change management: A critical review. *Journal of Change Management, 5*(4), 369-380. doi:10.1080/14697010500359250

Chapter 2: Empirical Paper

Clinical Psychologists as Multi-Disciplinary Team Managers in Mental Health Services: A Grounded Theory Study

Abstract

Objectives

There is limited research investigating clinical psychologists as managers. This study aims to explore clinical psychologist's experiences of the transition to a management role and their experiences working as a manager.

Design

A grounded theory methodology was selected to explore the experiences of this group and put forward an explanatory model of clinical psychologists' experiences of operating as a multi-disciplinary manager.

Method

Eight clinical psychologists working as multi-disciplinary managers were interviewed about their experience of moving into management roles and the impact of a psychology background on their management. The transcribed data was analysed using constructivist grounded theory (Charmaz, 2006).

Results

Following analysis, categories were developed to explain the experiences of participants. Factors influencing the move into management and the journey to gain management roles were identified. A grounded theory model was developed which represents the experience of working as a psychologist-manager. Identity was a core concept for participants and how identity was shaped through interaction with the self as both manager and psychologist. The organisations the participants were engaged with also influenced their identity. These areas are influenced by the wider pressures of the medical model, time, service user focus and threat. The concepts in the models link to narrative theories of identity.

Conclusion

Clinical psychologists operating as multi-disciplinary team managers have to adapt the language they used to construct their identity in order to adapt to their dual and sometimes conflicting roles. The narrative identities that participants held

influenced how they viewed themselves and consequently what actions were available to them.

Practitioner Points

Clinical Implications

- The way in which identity is constructed influences how participants applied both management and clinical skills.
- The reactions of other individuals and the organisation influence the way that participants feel able to work both clinically and in management roles.
- Providing positive professional experiences of innovation and management could encourage psychologists to pursue management roles.

Limitations

- Whilst a range of participants were interviewed for the study, theoretical saturation of the data was not achieved, therefore there could be additional factors influencing participants that were not identified.
- Participant validation of themes was not sought, which could have provided an additional measure of validity.

Introduction

The National Health Service (NHS), private and voluntary organisations, are designed to care for those experiencing mental health difficulties in the United Kingdom (UK). In the NHS, the size and structure of the teams providing care in these services varies according to service need and availability of resources. The NHS as an organisation is frequently subject to change, often linked to the political climate, effective clinical leadership and management have a significant role in implementing successful long term transformation of the NHS (Kings Fund, 2011). Therefore identifying staff who can best offer this type of management and leadership is particularly important given in considering how to manage the current challenges facing the NHS.

The importance of high standards in leadership from different clinical groups within the NHS was highlighted with the publication of the Francis Report into Stafford Hospital (Francis, 2013). The report recommended the introduction of a leadership college to provide training to staff at all levels with a focus on patient care (Francis, 2013). In addition, Chu, Emmons and Wong et al (2012) recognised some of the current difficulties facing the public health system and see the competency framework of psychologists as providing the leadership services required to manage these. The British Psychological Society (BPS) has highlighted the areas clinical psychologists can work within leadership roles in the Division of Psychology (DCP) Leadership Development Framework (Skinner and Toogood, 2010) such as constructing and sharing service development plans. Within the literature on clinical psychologists, the focus has been on leadership, rather than management. Llewelyn and Cuthbertson (2009) highlighted that while management and leadership are different, these roles can be linked by combining the skills required for the two roles. For example, inspiring trust and challenging existing structures while promoting order and solving problems. Deleon et al (2003) focussed more on specific management tasks, recognised the need for psychologists to become involved in areas of management such as public policy formulation, business, social planning and leadership. Despite the clear guidance and increasing literature on psychologists in management, there are still only small numbers of clinical psychologists moving into management posts.

The Clinical Psychology Forum, 'Leadership Challenges for Clinical Psychologists – challenge or opportunity' (BPS, 2012) provided an opportunity for commentary from different professionals, on the issues facing clinical psychologists in leadership roles. Ways to facilitate this move were also proposed. Steve Onyett highlighted that clinical psychologists should have developed skills fundamental to good leadership through training and clinical work (Onyett, 2012). Stevenson (2012) highlighted that psychologists possess a significant amount of information on leadership, but do not always implement this in order to promote their own profession. Moyes (2012) compared the techniques used by psychologists with clients to those used to understand organisations, putting psychologists in a position to apply theoretical models to the organisational context of the NHS, for example theories of group membership and how this might influence attitudes to

change (Moyes, 2012). Whilst these studies provide a useful commentary on the current position of psychologists in the field, the links to psychologists operating as good managers is not based upon research evidence. Based on these articles, it seems that clinical psychologists could have a role in leadership and management within NHS services; however, it is not a career path taken frequently by those in the profession which could lead to a lack of psychological influence in instrumental roles.

With changes to NHS structures and the increased pressure to cut costs it is proposed that by avoiding management and leadership roles, clinical psychology may be threatened by the dominance of the medical model. Commissioning of health services is an area where this dominance could be prevalent. Pemberton (2012) emphasised the role of psychologists in commissioning to ensure leadership by psychologists is not restricted. Pemberton's (2012) statement is particularly significant in light of a report by Lord Layard (2012) as part of the London School of Economics. This report described psychiatrists as leading experts within mental health and for psychiatry to remain attractive, the move to other professions leading secondary services should be reversed in favour of psychiatrists. In order to manage the pressure of the medical model within management in the NHS, clinical psychologists need to take on the challenge of engaging with leadership opportunities in an organisation likely to continue to be dominated by medical doctors (Hodgetts, 2012). Ball (2010) viewed doctoral training programmes as key in preparing clinical psychologists for the challenges of management. Whilst organisational understanding is a clinical competency for those training in clinical psychology, further evidence on the impact of educating clinical psychology trainees about organisations would be required for this area to receive more of a focus in clinical training.

In the literature, the importance of clinical psychologists engaging with leadership and management to maintain a psychological influence in mental health services has been identified, as have some of the perceived reasons why a psychological background may support good leadership. However, there is little research to support or refute this and limited research on why psychologists choose a managerial role. Exploring some of the skills psychologists use in management roles will provide evidence of the contribution of psychologists to healthcare

management and can provide opportunities to enhance training. Due to the scarcity of research in this area and a focus on understanding the experiences and social interactions of a group, grounded theory is an appropriate methodology to explore these areas and develop a framework to represent the experiences of the group. Grounded theory is a suitable methodology where the aim is to explore the processes underlying the behaviour of participants (Charmaz, 2006) and the research is not aiming to test predefined hypotheses (Mills, Bonner and Francis, 2006).

The aims of this research were to develop an understanding of why clinical psychologists in the NHS make the move from practitioner to multi-disciplinary team manager and what impact a psychology background has on this role. From this aim, the interviews focussed on: how clinical psychologists move into management, the impact of a psychological background on the management styles of psychologists, and the impact of psychologist managers on the services they manage and the service users engaged with the service.

Method

Procedure

Ethical approval for the study was granted by Staffordshire University. Research and Development approval was sought from each Trust that was approached for the study. Participants were identified through contact with Research and Development Teams of NHS Trusts and an invitation to participate sent through the email list of the Leadership and Management Faculty of the Division of Clinical Psychology (DCP). Potential participants received an invitation to participate via email with an information sheet and consent form attached. Following provisional agreement to participate in the study an interview was arranged. Five interviews were conducted face to face and three by telephone. Consent was obtained prior to commencing the interview. Semi-structured, audio-recorded interviews were conducted with each participant lasting between 30 and 75 minutes long. Interviews were transcribed for analysis, four by the researcher and the remaining four by a professional due to time constraints. The interview covered three main areas: factors influencing the move from practitioner to manager, influence of a psychological background, and the impact of a psychological background on the

service and service users. Through the interview process, areas for exploration were identified which led to adaptations to the interview schedule.

Participants

To be eligible for the study, participants needed to have multi-disciplinary team management and leadership responsibilities within an NHS service. A multi-disciplinary team is defined as a team comprising staff members from different professions such as community mental health nurses, occupational therapists and psychiatrists. Demographic information has been kept to a minimum. Eligible participants were limited and therefore including any further information would increase the likelihood that those who chose to participate could potentially be identified. Some participants also expressed concern about being identified as an individual or identifying their employing Trust as they had discussed problems they were experiencing within their organisations and had concerns that this could lead to negative consequences. Eight participants agreed to participate in the research. Four participants were male, four female with an average age of 46.5 years. The average time since qualifying was 18 years, with an average of 9 years in management. Six participants retained a clinical workload alongside their management roles. Participants practised from a range of perspectives including cognitive behavioural, systemic, psychodynamic and attachment with all implementing theory from more than one perspective. Four of the participants also held additional qualifications in neuropsychology.

Researcher Context

In analysis of qualitative data, it is important to consider how the experiences of the researcher may influence the way that data is analysed in order that the reader can consider any particular bias that may be present (Charmaz, 2006). At the time of writing, I am employed as a trainee clinical psychologist within an NHS mental health trust. This involves working with clients therapeutically from a variety of orientations including cognitive behavioural, systemic, psychodynamic and behavioural. My favoured approaches are intensive short-term dynamic psychotherapy and cognitive behaviour therapy with clinical work conducted with adults, children and young people. I have previously worked as a manager within a service and it was as a result of this that I developed an interest in the roles held

by psychologist-managers. I applied a grounded theory methodology from a contextualist epistemology. A contextualist epistemology comes from the perspective that knowledge gained is specific to the cultural context of the participants and the researcher as I share a similar environment to the participants so believe that I will have worked with participants to understand the areas discussed (Madill, Jordan and Shirley, 2000). Within this epistemology both the interviewer and the participant construct an understanding of the phenomenon being studied together.

Analysis

As each interview was completed, the recording was transcribed and line-by-line coding was conducted in line with grounded theory methodology (Charmaz, 2006). This allows for constant comparative analysis and refining of the interview questions (Charmaz, 2006). At this level, the codes assigned are in the form of actions to keep the coding focused on the processes or actions participants are engaging in (Charmaz, 2006). Following line by line coding, focused coding was applied to the transcripts (See Appendix 8). Focused coding allowed for the most important and frequent codes to be assimilated by identifying the most frequent or significant codes to make sense of larger sections of data (Charmaz, 2006). The focussed codes were grouped together based on what the researcher felt were similar areas and assigned categorical headings. Theoretical coding was then applied to the categories to look for relationships between the categories and start to indicate a link to relevant theories (Charmaz, 2006). Memos were developed throughout the analytical process on any ideas that arose from the interviews or coding. Memos were refined as further data was gathered to shape the analytical process and provide evidence of how the analysis and development of the model progressed (See Appendix 9).

Results

As a result of the coding process, the following categories were identified relating to the transition from clinician to manager and the experience of operating as a multi-disciplinary manager (Table 1).

Table 1: Categories

Transition to Management	
Category	Sub-category
Prior experience	Early life experiences Training Early career
Making a decision	Making my own decision Being put in a position
Taking steps	Gaining experience Making use of relationships Personal attributes Experiencing barriers
Experience of Being a Manager	
Identity	Personal Professional Management
NHS Trust	Psychology impact on NHS Trust NHS Trust impact on psychology Context
Being a Manager	Relationships Organisational Responsibilities Managing Challenge and Change
Applying Psychological Skills	Generic Specialist
Personal Development	Self-reflection Building on knowledge
Contextual Factors	Medical Model
	Service User Focus
	Threat
	Time

Transition to Manager

Prior Experience

The category of prior experience incorporated three areas: early experiences, training and early career. Early experiences included the type of subjects taken at school, leisure activities that promoted leadership and career experience prior to embarking upon clinical training.

> "I had a very inspirational supervisor when I was an assistant psychologist who was interested in management and leadership and how organisations worked." (Participant 6) line 28-31

Factors from clinical training related to seeing changes to the profession and planning for the future and placement experiences.

> “I developed, when I was on training, an internal sense of how I wanted to be as a clinical psychologist . . . . he juggled being . . . . manager of CAMHS with working as a clinical psychologist, and he did that, I felt, very successfully. . . . and so I had an optimism that you can do this. That you don’t have to do, do, one or the other, and I think that’s been quite influential more than anything particularly that was covered or that could be taught.” (Participant 4) lines 91-98

In participants early careers, some had been able to take on projects that increased their confidence in taking on new challenges and developing their skills or alternatively feeling frustrated with a lack of ability to make changes.

> “I couldn’t control [any of] what [how it] was done or how it was spent because I had no control over the budgets and it started to become an issue for me then that I had no control over how the money was spent.” (Participant 1) lines 133-135

No participants experienced all these factors. The intensity and duration of these experiences varied across the participant pool.

Making a Decision

Making a decision was a continuum across the participants. Participants at one end of the continuum made a definite decision to manage. For one participant this occurred during clinical training in the hope of achieving job security in a challenging environment.

> “I think during training it became quite apparent that um, [.] jobs for psychologists were going to be taken over by lower qualified, more generic mental health workers doing CBT so it was a kind of strategic decision to kind of specialise much earlier in my career.” (Participant 2) lines 82-86

At the other end of the continuum participants felt pressure to move into management due to the needs of their employing organisation.

> “It was just kind of suggested that I did it in a fairly forceful kind of way. I suppose realistically I could have said no, I’m absolutely not doing that, but that probably wouldn’t have done me very much good in the long term.” (Participant 5) lines 83-86

For other participants, making a decision was an interaction between an opportunity in the organisation and a decision to make the move to manager. Those who made conscious decisions to seek management roles were faced with challenges in finding a role.

Taking Steps

To secure a managerial role, participants moved areas, took secondments, utilised relationships and looked beyond traditional psychology roles.

> “What occurred to me there was no way of getting operational management experience …… I had a good relationship then with the director who was in post…… he said to me would I like to take the role on the same band as I was on now as a secondment.” (Participant 1) lines 141-163

Where participants were influenced more by the organisation, incidental experience was required for the move to management to be made. This took the form of cover, interim roles and secondments.

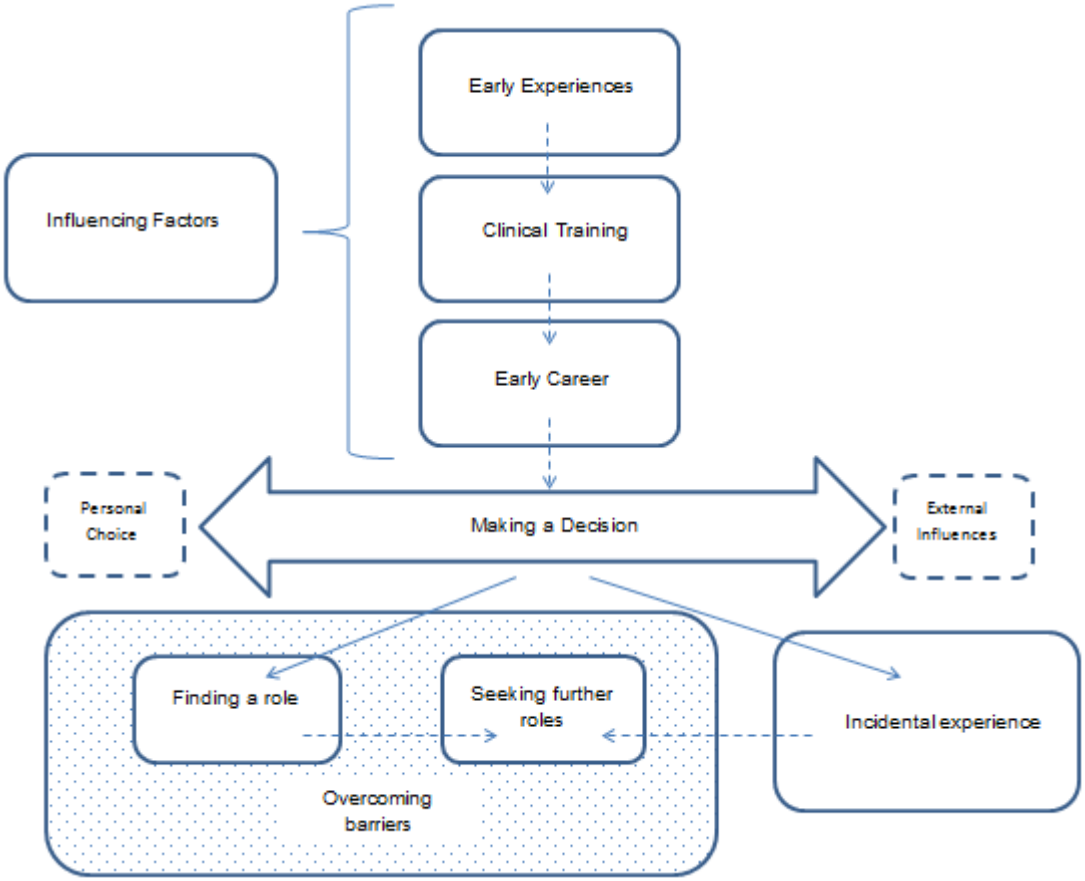
> “The person who got the post permanently was also, the day she got the post, about to go on maternity leave. So, they knew they needed, they asked me to take it over, with the remit of looking at some of the psychological functioning of the team and cutting back on my clinical work.” (Participant 3) lines 34-37

Regardless of the influences on the initial move to management some participants then went on to seek further management roles. For some, they were still in their first management role. The barriers experienced by those who sought management roles were experienced by those seeking further roles and were overcome in the same ways.

> "I do know in some areas people do find it difficult to break into management leadership roles, which aren't within psychology. So, I think that's, that's, you turn to individuals to challenge that and go for opportunities when they come up and look beyond just psychology posts." (Participant 6) lines 63-66

The categories and sub-categories developed from the participants' descriptions of their transition to management are represented in Figure 1.

Figure 1: Transition from clinician to clinician-manager



The Experience of Being a Manager

Identity

The category of identity relates to how participants viewed themselves within their clinician-manager roles. This had three sub-categories: personal, professional and management. The personal identity incorporated ideas related to how the

participants were as individuals, for example, level of confidence. The professional and management categories related to how participants viewed themselves as a psychologist and a manager. In some instances, the different parts of identity complemented each other while at other times balancing multiple identities could be difficult to manage.

> "I suppose [a] disadvantage is because I'm a clinical psychologist my time is taken away from that to do other things for the Trust. So, that would be the same, so, then there is less availability for the service users… so much of my time is pulled into meetings, you're not seeing families. But, hopefully the longer term benefits are there." (Participant 4) lines 174-179

NHS Trust

The relationship that the participants held with their employing NHS Trust influenced the roles that were available and the tasks required to be undertaken. The NHS Trust influenced how psychology was perceived within the organisation, and also the way that psychology had engaged with the Trust historically impacted upon how the Trust viewed the profession.

> [Discussing impact of two senior psychologists] "You've got that three different levels, at local level, sort of NHS level, also trust level and psychology working indirectly in more leadership and management roles has been promoted." (Participant 7) lines 247-250

Being a Manager

Being a manager encompassed organisational obligations such as managing budgets and developing relationships that supported their continued work in management. Some participants discussed the difficulty in maintaining their managerial identity alongside their identity as a psychologist. As part of the managerial role, participants were expected to utilise the formal structures to manage performance. This could conflict with the values that participants held as a psychologist of being person centred and supporting staff through difficulties.

> "I think there's a real tension for senior psychologists around what they're required to do in terms of their job role perhaps, you know from a trust/organisational perspective, and what your requirements are on the ground. So, psychologists I think, certainly in our organisation would be the professional that's expected to be the most caring, the most considerate, the most able to deal with a difficult situation….. Whereas I think some of the things that, you know, use of some of the Trust's policies makes it really hard to do that." (Participant 5) lines 457-475

Applying Psychological Skills

Participants recognised several areas where they continued to use their psychological skills. Generic skills were related to the core abilities participants felt were required in their ability to work as a psychologist such as applying theoretical models, displaying empathy and research. In addition, participants recognised the benefits of applying specialist skills such as specialist theoretical models and neuropsychology accreditation. These skills were applied to both the service users participants worked with and the staff that they managed.

> "it's just not losing sight that your clinical skills are the same whether you're working with a staff group or with clients really. Kind of working with staff it's still about getting that relationship with them, focussing on that as the prime thing that's gonna drive, you know as much as in therapy, a prime driver is that relationship." (Participant 3) lines 205-209

There was an acknowledgement that while these skills were helpful in supporting staff effectively some caution should be applied in using psychological skills with staff. Potentially staff could resent being supported in the same way as service users.

> "I will formulate a person's strengths and weaknesses based on their defensive structure and then support them using mentoring strategies, but keeping an eye on that….. Because obviously I'm not the person's therapist and I think the staff really resent being

> therapised by a clinical lead who's also a therapist." (Participant 2) lines 274-283

Personal Development

Participants approached their personal development within the role differently. For example, seeking structured management or psychological training programmes, self-directed learning in or understanding their own strengths, weaknesses and personality structure.

> "Personally I enjoy learning but also I think I've got a responsibility in a leadership role to be fully informed and to grow and develop. So just like any area of work, leadership and management don't stay static so you do need to continue to learn and develop; otherwise you're kind of doing no favours to your staff group or to your organisation are you? So, yeah, it's basically to ensure that I am doing the best I can, you know with the best knowledge base to do a good job." (Participant 8) lines 739-748

Contextual Factors

There were four contextual factors that had an impact on the overall experience of being a manager: medical model, time, threat and service user focus. Several participants discussed feeling a sense of threat. Threats were perceived towards the profession, NHS services and resources. One of the threats felt was from the medical model. This was a dominant concept within mental health and was perceived as a barrier to be worked around or an area where steps had been taken to promote integration.

> "I mean basically we're still faced with the challenges of working in a basically medically immersed model. You know that fundamentally in terms of performance management in the NHS hasn't changed." (Participant 6) lines 330-331

The impact of the medical model shifted over time as ideas about mental health services had adapted and some Trusts had shifted their position to seeing medical and psychological models as more complementary. Time related to the shift in the

threats experienced. There had been an increase in the number of psychologists and progress in understanding mental health but despite this, there were concerns about the stability of jobs and the future direction of the profession. This was particularly pertinent with the financial difficulties faced by NHS services in the current climate.

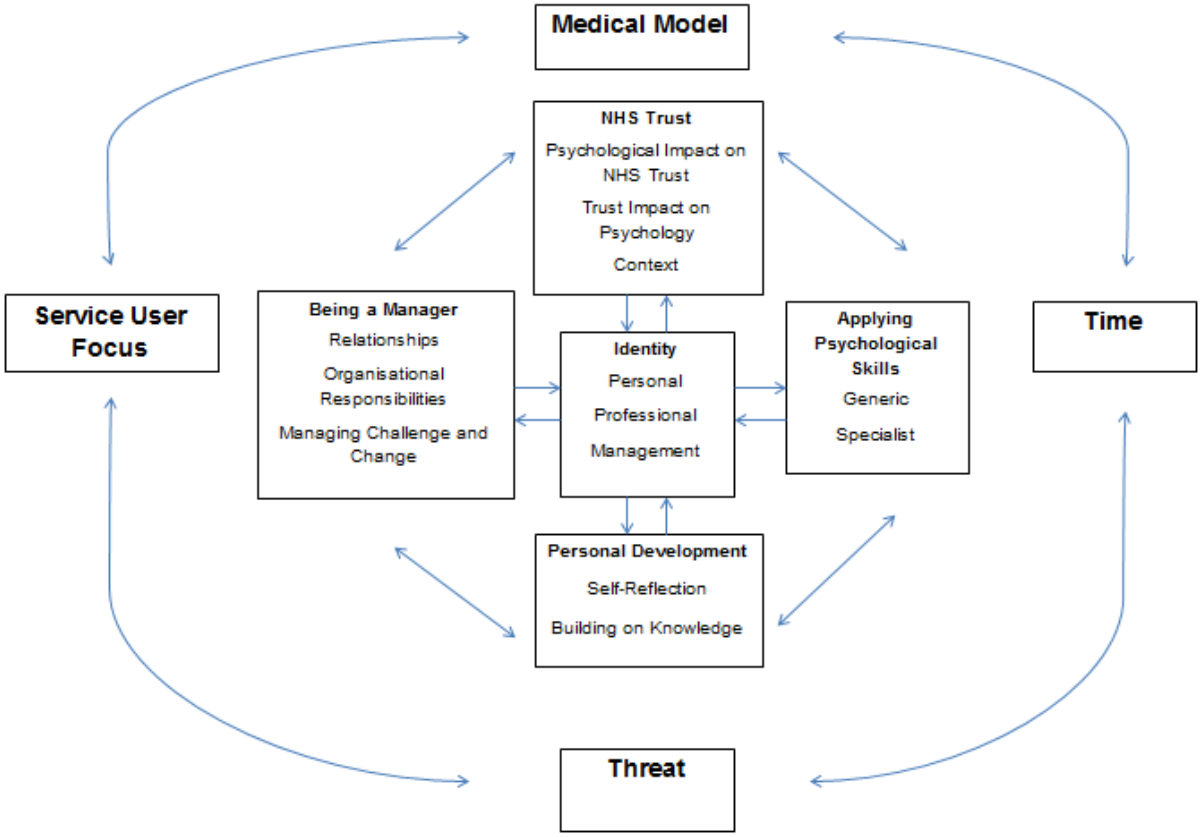
> "I worry about what's happening within the profession and how things are going to unfold because we're very expensive within today's modern NHS and I'm not necessarily sure that people really still see the value of psychology." (Participant 5) lines 920-924

Service users were very much a focus of participants, whether it is in their role as manager or clinician, it was linked back to the impact on the service users. Shifts in medical and psychological understanding influenced the way service user difficulties were perceived and the challenge was to continue to deliver high quality services in the current context of threat to resources and services.

> "It's the end, you know, the most important person is in the middle of all this morass of information that we have to get right, to get the right clinician in front of the right person." (Participant 8) lines 315-318

Constant comparative analysis was undertaken as the interviews were conducted. This allowed for ideas as to how the experiences described by participants were related and what further areas warranted exploration. Memos were kept to monitor ideas on how emerging categories related. As a result, a grounded theory model was developed to represent participant's experiences of being a multi-disciplinary manager within the NHS (Figure 2).

Figure 2: Being a multi-disciplinary psychologist-manager



Narrative Model: Being a multi-disciplinary psychologist-manager

The model illustrates the relationships between the categories developed through the analytical process. Identity was a central concept of participant's experiences of being a manager. Participants' identity was influenced by their experiences of undertaking management tasks, the relationships between psychology and the NHS Trust, applying their psychological skills and how they viewed continuing their personal development. How participants approached these aspects of their role was influenced by their identity. Where skills were implemented successfully, these were incorporated into participant's identity. Where the different aspects of the roles conflicted there was an attempt to make sense of these experiences and balance the different aspects of their identity. The different aspects of identity were influenced by the wider contextual factors of threat, service user focus, time and the medical model. For example, the way the medical model is understood by the

NHS Trust influenced how participants constructed their knowledge, the opportunities provided by the NHS Trust, how participants understood where their psychological skills could be utilised and how much power or challenge they felt within the managerial role. The contextual factors also interacted. For example, the conception of the medical model has shifted over time as how mental distress is understood has evolved. Furthermore, a service user focus has led to an increase in the need to offer choice to service users regarding their care and offering alternatives to a biological understanding of their difficulties. However, some participants still experience the medical model as restricting the application of psychological ideas, particularly at a time of threat where resources are reduced.

The analysis of participants' experience of the transition to a managerial role explored the factors that influenced their decision making, the types of decisions participants made and how they secured management roles. The grounded theory model of participants' experiences of being a manager highlighted the core category of identity in shaping how participants approached their roles and what factors shaped their concept of their identity. The model also recognises the impact of contextual factors on participant's roles.

Discussion

The model of participants' experience of being a multi-disciplinary manager highlights identity as a central concept that is shaped by their experiences. Experiences of managing, working as a psychologist, engaging in personal development and working with the Trust shaped how participants viewed themselves as a psychologist-manager. All these factors are impacted by the contextual factors of threat, time, the medical model and maintaining a service user focus. This model linked to narrative theories of identity development, specifically Somers (1994). Somers (1994) proposed a relational and network approach to the construction of narratives of identity. Somers (1994) suggests a move away from seeing identity only in terms of fixed categories such as gender, instead seeing people constructing narratives of their own identities that help them to understand who they are. An individual's understanding of who they are provides them with an awareness of what actions are available to them.

Individuals can then choose to take a particular action or not. The action taken then develops the narratives available leading to new available options and continues in a circular manner. The identities constructed can be numerous and potentially conflicting. Narratives are shaped by social and interpersonal interactions, families and institutions, as well as the wider narratives of society, time and space. Struggles over identity are a struggle with narratives.

In this study participants reported difficulties reconciling the empathic, person centred stance of their identity as a psychologist with the more authoritarian, mechanistic performance management procedures they were expected to utilise as a manager. In the model proposed, participants have developed narrative identities about the different roles that they hold as psychologist and manager. Their previous experiences, and the organisations and professional groups they belong to shape these identities. The narrative identities have developed and changed over time and have been influenced by the wider cultural ideas of the NHS, psychology and political agendas. Participants' ideas about available actions, such as job opportunities, and whether they choose to take them are shaped by the narrative identities they have developed. For example, adapting their narrative of their identity as a psychologist to one of a psychologist manager provided them with a different set of potential actions.

Research by Chu et al (2012) and Deleon et al (2003) considered the role of clinical psychologists in leadership and management by using their clinical competencies and moving into policy formulation and business planning. This is congruent with how those psychologists employed in management roles described incorporating their skills in managing services and the range of tasks they undertake. Explicitly incorporating leadership and management into the awareness of clinical psychology is a relatively new move with the DCP Leadership Development Framework (Skinner and Toogood, 2010) and the incorporation of a broader organisational and systemic influence and leadership competency (BPS, 2014) that highlights how wide organisational work can be while training. However, despite these moves there are only limited numbers of clinical psychologists who have engaged with formal management positions. This may change as the profession continues to integrate more management and leadership development into training and professional guidance. Further research is required to explore the

real world impact of the increased attention to management and leadership on psychologists and why psychologists choose to avoid these roles.

Whilst there is a lack of quality empirical research on the area of psychologists operating as managers, there are some case studies that have described managers in these positions. These papers predominantly relate to industrial/organisational psychologists working in America. There are areas that relate to the model developed in this study within this literature. Kelly and Finkelman (2011) propose communication skills and interpersonal sensitivity as essential to the success of being a psychologist and a manager. In support of this, Goodstein (1991) and Ball (2001) recount how their transition to management occurred purely by chance events and existing relationships. Hollenbeck (2013) links his management skills to his prior work and early experiences in a similar way to that of the participants in the current study. Whilst the case studies show some consistency with the findings in the current study, there are issues with reliability and validity due to the studies being case studies from a first person perspective.

The area of clinical psychologists in management roles is limited and the available research is theoretical or lacking rigour. This research provides information on the transition into management of psychologists and the experiences of the participants of operating in these roles. These experiences link to narrative theory and provide some context to the available research theoretically proposing the skills applied by psychologists operating as multi-disciplinary managers.

Limitations of the study

The study met the minimum number of participants recommended for qualitative research with a population whose experience is homogenous (Kuzel 1992, in Limb, 2004). It is not felt that the sample enabled theoretical saturation of the data. Theoretical saturation is when nothing new is found in newly gathered data. This is sought by theoretical sampling, seeking out further participants specifically to refine and expand upon categories that are emerging in the data and to try to find participant experiences that do not fit with the developing model (Charmaz, 2006). The concept of theoretical saturation is a debated term in qualitative research with one argument being that there will always be new aspects of a story to discover

(Wray, Markovic and Manderson, 2007). A range of different participants were interviewed for the study in terms of age, geographical location, time since qualification and preferred psychological frameworks in an attempt to capture a range of experiences of the group. However, it is felt that if there had been further participants available within the time constraints of the study, this would have allowed for further checking as to the scope of the model to explain the widest range of experiences of participants in this group.

Participant validation of the models was not sought. The aim of grounded theory is to describe the experiences of a group rather than the individual (Charmaz, 2006). It was felt that checking the models with participants would have limited validity as they may be unable to see clearly their individual experience within the whole model. Instead, supervision with a clinical psychologist employed as a manager was utilised to discuss ideas and to reflect on any bias in the interpretation of the data. Supervision was utilised as the supervisor had an overview of the data and how they were synthesised into a model as well as an understanding of the world inhabited by the participants. Group supervision with others familiar with grounded theory provided a method to assess whether the process from analysis to model was clear. In addition, line by line coding of the initial data was conducted rather than analysing larger units of data to keep the interpretation grounded in the data.

Implications of the study

The findings of the study have implications for clinical training and the support provided for those wishing to pursue a move into management. In terms of clinical training, participants felt they received little support in topics that would have supported a transition into management. Further teaching and development in areas of supervision, group dynamics, managing budget and developing business cases could help to prepare those wishing to make the transition and develop confidence in these skills. Shifts in clinical training have seen the inclusion of organisational understanding as a training competency, however, due to the time since qualifying of most of the participants these changes will have had limited impact on their experience of training.

In terms of support for those wishing to transition from clinician to clinician-manager, some participants cited the difficulty in obtaining support from within the

profession due to the scarcity of psychologists operating in this capacity. Developing a mentoring scheme for those aspiring or new to management could help in skills development and feeling secure within management roles. One participant who had experienced mentoring during their time as manager valued this in their development and progression. When considering support in relation to the narrative identity theories cited this could provide a framework to help those making the transition to understand any conflicts they experience and expand upon stories of success. Narrative identity ideas could also be applied to those in training to explore their ideas about psychologists as managers and prepare them for the potential dissonance they may experience if faced with these opportunities in their careers.

Areas for future research

Following this study, there are areas that could benefit from further exploration. This study provided an understanding of those who move into management, however, there is no research on those who make the decision to stay within a clinical role. A similar study could explore the processes involved in making the decision to stay in a clinical role and comparing the processes involved in working in a multi-disciplinary team as a clinician to a clinician-manager. This study focussed exclusively on clinical psychologists who had moved into management, and further research could explore the transition for other professions such as nurses. This would explore whether the processes in decision making and establishing a dual role identity are similar to those experienced by clinical psychologists. This could provide better identification and tailored support for those wishing to manage NHS mental health services.

Conclusion

The findings of the study link the experience of taking on a dual role with narrative identity work to reconcile a potentially challenging career transition and negotiating what can be conflicting roles. The grounded theory model conceptualises the processes for clinical psychologists in MDT roles in NHS mental health services. It provides some initial views as to the challenges faced when undertaking these roles in the current NHS while providing some hypotheses about how to support those wishing to make these career choices.

References

Ball, J. (2010). Professional development: Mine and theirs. *Journal of Clinical Psychology in Medical Settings, 17*(4), 326-332. doi:10.1007/s10880-010-9215-2

Ball, K. L. (2001). Managing in ongoing crises: A psychologist-manager case study. *The Psychologist-Manager Journal, 5*(1), 15-20. doi:10.1037/h0095898

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE.

Chu, J. P., Emmons, L., Wong, J., Goldblum, P., Reiser, R., Barrera, A. Z., & Byrd-Olmstead, J. (2012). The public psychology doctoral training model: Training clinical psychologists in community mental health competencies and leadership. *Training and Education in Professional Psychology, 6*(2), 76-83. doi:10.1037/a0028834

DeLeon, P. H., Giesting, B., & Kenkel, M. B. (2003). Community health centers: Exciting opportunities for the 21st century. *Professional Psychology: Research and Practice, 34*(6), 579-585. doi:10.1037/0735-7028.34.6.579

Francis R (2013) *The Mid Staffordshire NHS Foundation Trust, Final Report of Public Inquiry, HC 947*. London: The Stationery Office (TSO).

Goodstein, L. D. (1999). Meandering to the top: A personal and professional odyssey. *The Psychologist-Manager Journal, 3*(1), 71-83. doi:10.1037/h0095858

Hodgetts, D. (2012). Commentary on Onyett: Challenge or opportunity? '…Well both really, and usually simultaneously'. *Clinical Psychology Forum*, 238, 25-27.

Hollenbeck, A. R. (2013). The journey of a psychologist-management consultant in a nonprofit member organization. *Psychologist-Manager Journal (American Psychological Association), 16*(2), 79-84. doi:10.1037/mgr0000002

Kelly, L., & Finkelman, J. M. (2011). The psychologist manager: Uniquely qualified to address 21st-century leadership challenges? *The Psychologist-Manager Journal, 14*(3), 196-210. doi:10.1080/10887156.2011.595980

King's Fund (2011). The future of leadership and management in the NHS: no more heroes. *Report by The King's Fund Commission on Leadership and Management in the NHS*.

Layard, R. et al. (June 2012). *How Mental Illness Loses Out in the NHS. London School of Economics Centre for Economic Performance's Mental Health Policy Group*. Available from http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf

Limb, M.K. (2004) Using grounded theory in qualitative health care research. In Bassett, C.C. (Ed.) *Using qualitative research in health care.* London: Whurr Publications.

Llewelyn, S. & Cuthbertson, A..(2009), Leadership, teamwork and consultancy. In H. Beinart, P. Kennedy, & S. Llewelyn, S. (2009) *Clinical Psychology in Practice*, Blackwells, pp.350-363

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemiologies. *British Journal of Psychology, 91*(1), 1-20. doi:10.1348/000712600161646

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *Journal of Qualitative Methods. 5*(1), pp. 25-35.

Moyes, T. (2012). Commentary on Onyett: Challenge or opportunity. *Clinical Psychology Forum*, 238, 28-30.

Onyett, S. (2012). 'Leadership challenges for clinical psychologists' – challenge or opportunity?. *Clinical Psychology Forum*, 238, 10-16.

Pemberton, R. (2012). Commentary on Onyett: Skilled professional leadership has never been more needed. *Clinical Psychology Forum*, 238, 24.

Skinner, P. & Toogood, R. (Eds.) (2010). *Clinical psychology leadership development framework.* Leicester: British Psychological Society.

Somers, M. R. (1994). The narrative constitution of identity: A relational and network approach. *Theory and Society, 23*(5), 605-649.

Stevenson, H. (2012). Psychology at work. *Psychologist, 25*(4), 259-259.

Wray, N., Markovic, M., & Manderson, L. (2007). “Researcher saturation”: The impact of data triangulation and intensive-research practices on the researcher and qualitative research process. *Qualitative Health Research, 17*(10), 1392-1402. doi:10.1177/1049732307308308

Chapter 3: Reflective Paper

The Research Journey: traffic, road works and diversions

Introduction

Navigating the research journey has been akin to using the midlands motorway system. You select a destination and plan your route. Some days you get stuck in traffic and the journey takes much longer than anticipated, other days you pick a diversion to avoid road works and find a more desirable route. Just when you think the road works and delays are finished, another one pops up. My desired destination was to gain a clearer understanding of the routes taken into multi-disciplinary team (MDT) management roles by clinical psychologists. In addition, I was interested in how participants experienced the dual role of clinical psychologist and MDT manager. Through consultation with research and field supervisors I designed a study of 'Clinical Psychologists as Multi-Disciplinary Managers: A Grounded Theory Study' with a literature review of staff experiences of organisational change within mental health services in the UK. The traffic on this research journey has been organisational ethical approval processes, recruitment and the anonymity concerns of participants. From the outset of designing this study, I considered how to simplify these gaining approval and recruitment aspects of the study as I anticipated that they could be a challenge. I was then surprised when these became the most significant hurdles to overcome. The worthwhile diversions through this process has been developing my knowledge of staff experiences of organisational change and increasing my self-awareness of my psychological defences. At the outset of the study I had not considered the personal discoveries I might make with regards to how I responded to different situations in the research and the reasons why. Through the ongoing study of different psychological frameworks in my clinical placements I was able to understand my responses to different situations within the research using an Intensive Short-Term Dynamic Psychotherapy (ISTDP) framework. ISTDP focuses on understanding psychological distress in terms of unconscious feelings that are difficult to express triggering anxiety (ten Have-de Labije and Neborsky, 2012). Psychological defences such as avoidance and repression to manage these feelings and the anxiety they provoke. The relationship with the therapist provides information on how the defences, anxiety and the unconscious feelings are expressed in the client's relationships. In order to do this, the therapist needs to have an understanding of their own psychological structure and how that might

influence therapy. This provided me with an understanding of my psychological defensive structure and where these structures had originated in my past. I was able to better understand why I responded to particular situations with increased anxiety and identify strategies to manage both the anxiety and the potential impact of my psychological defences.

Ethical Approval

Ethical approval processes are a necessary part of any research project in order to protect participants from any form of exploitation or abuse. However, navigating the different routes to approval can be a confusing experience depending upon where participants are recruited from, the nature of the information being sought, and the need to consult with multiple organisations. In designing my study I had considered the ethical implications of working with NHS staff and carefully considered the information I wished to gain in an attempt to avoid any ethically delicate areas. As the study was focussing on experiences of being a manager, it was not anticipated that this would expose any sensitive areas. The study would only be including NHS staff members and as a result would need organisation approval from the university before proceeding to gaining Research and Development approvals from the relevant NHS Trusts. At first glance, this appeared a straightforward procedure given the nature of the study. I had accounted for a maximum of six months to complete the required ethical and research and development approvals, however, from starting this process to approaching the first participant required twelve months. This was as a result of a lack of clarity over which organisation, the university or the NHS Trust, needed to approve the study first with both organisations citing the other. In order to resolve this, it was necessary to identify key participants within each organisation to offer support with a resolution and maintain regular and clear communication as to the progress of the approval process. Fortunately, with support from the university ethics panel, the clinical psychology doctorate team and my employing Trust, ethical approval was granted. The delay had set the project back quite significantly; my concern was that recruitment was then commenced after the summer teaching break which limited my availability to conduct interviews. Due to difficulties gaining participants, this was less of a challenge than anticipated. Through engagement with this challenging process it further reinforced the value

of identifying key figures for support and engaging in regular communication to resolve difficulties. This learning was fundamental in managing the challenges I then faced with recruitment as well as in my clinical work when difficulties arose.

Recruitment

When consulting on the development of the study with field and university supervisors it became clear that the participant pool of clinical psychologists as multi-disciplinary managers was limited. However, research on the numbers required for doctoral level, grounded theory studies indicated that eight participants would be sufficient and it was decided that this figure was achievable (Kuzel 1992, in Limb, 2004). Identifying participants within this role was the first challenge. There was no simple way to obtain the names of potential participants and the roles occupied varied greatly between Trusts in terms of whether job titles encompassed a multi-disciplinary management aspect. My initial recruitment strategy was to contact Research and Development teams of NHS Trusts to request names of potential participants. The ability of NHS Trusts to provide this information was variable, some research and development departments had a lot of knowledge on the roles and responsibilities of the senior psychologists in their Trusts while others did not. Furthermore, due to the senior roles occupied by participants it could be challenging to initiate and maintain contact as their schedules were incredibly busy. Consultation with supervisors was undertaken as to the best way to increase recruitment as the strategy of contacting Research and Development Teams was not yielding many participants. In addition, applying for ethical approval from each Research and Development Team was a time consuming process which did not always lead to recruitment of participants. It was decided that approaching the Leadership and Development Faculty of the Division of Clinical Psychology (DCP) within the British Psychological Society (BPS) may lead to identification of interested parties. Consequently, an expression of interest was sent by the committee and this provided enough participants to complete recruitment. It was also a more economical use of the time I had available to complete the study as it meant applying to Research and Development Teams in NHS Trusts where I knew that there was an interested participant.

Potentially related to the difficulties with recruitment were the concerns of participants about maintaining anonymity. Due to the relatively small numbers of participants there is a possibility that participants could be identified if someone they knew read the results of the empirical paper. This concern was raised by some participants during the interviews. This arose specifically when discussing some of the difficulties of the roles they occupied as a result of working within their NHS Trust. The conflict participants experienced appeared to be that they wished to provide full disclosure about their roles but worried that expressing negative views about their employers could have adverse consequences for their roles. In order to manage this I discussed with participants the demographic information that would be presented and that all quotes would be sufficiently anonymous to preclude identification. Again, support from the university team to guide me through this challenge was invaluable. The support provided guidance on alternative strategies, contact details of relevant people to help with adapting the recruitment procedure, as well as moral support and reassurance that gaining participants and completing the study was achievable in the available time. While this was initially another traffic situation that further held up the study, I was supported in identifying an appropriate diversion to circumvent the block.

Understanding Staff Responses to Organisation Change

The NHS is an organisation that undergoes frequent change and this is certainly something that I have encountered through the different teams I have been a part of throughout training. By reviewing the literature relating to staff experiences of change in mental health services in the UK, I not only increased my understanding of an area I have an interest in, I was also able to apply this learning to better understand the dynamics involved in organisational changes that I witnessed. As an observer of change, I was able to witness how different staff responded to change and how the organisation approached development and implementation of changes. I could then relate this to the literature that I had reviewed. For example, when hearing professionals discuss change on a one-on-one basis, conversations were generally more positive than those expressed in a group, which was reported in a study included in the review (Greenwood, Ryan, Keaveny and Deo, 2007). By seeing change as a live process in the service I was engaged with, it brought the studies included in the review more to life; as a result I decided to include a model

of organisational change derived from the results of the studies and amalgamated with theories of organisational change by Lewin (1952) and Kotter (1995). By seeing first hand organisational change following completion of the literature review I was able to consider the studies in a real-life context from the first person and this supported my engagement with the review and how to apply the findings within my job role.

Increasing Self-Awareness

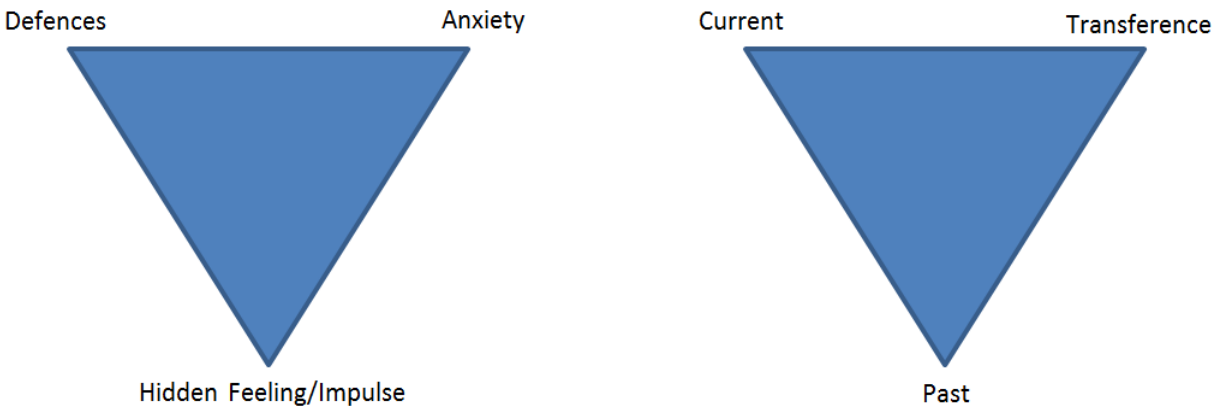
When conducting qualitative research it is important to consider the influence of the personal on the professional to ensure thorough assessment of what bias is being introduced into the data. How we see the world, our previous experiences and personality structures influence how we perceive knowledge, interactions with others and what we interpret in the data. The study utilised a grounded theory approach which is a qualitative approach that involves analysing the data as it is gathered in order to identify areas of interest for further exploration (Charmaz, 2006). Prior to starting the study I considered my epistemological position with regards to how I see knowledge as existing in the world and how this influenced my ideas about how to conduct my study. It is my belief that when analysing qualitative data I cannot suspend the knowledge and experiences I have and as a result I selected a constructivist approach to grounded theory developed by Charmaz (2006). I used this approach as it was cohesive with my view that knowledge gained through the use of qualitative research is specific to the time and place it is gathered and is constructed between the researcher and the participants. This was particularly congruent with this research project as I shared a similar social world and background to that of the study participants. Whilst I had considered the epistemological position that I held prior to starting the study, throughout the research process it became clear that there were other factors which influenced my research. One of the main factors were the psychological defences that I was accustomed to using. These were highlighted to me during the research process as I was working on an adult mental health placement, practising ISTDP. This approach looks in detail at psychological defences of a client, their anxiety presentation and what feelings are being kept in the unconscious. In order to deliver therapy effectively within this model, it is important for the therapist to be aware of their own defensive structures. Through reading, practising and being

supervised in this model I developed an increased awareness of the defences I had been habitually using and the impact of these defences. Using the support of both clinical and research supervisors I was able to consider what defences were being activated at different stages of the research process and how I could challenge these effectively.

Introduction to Intensive Short-Term Dynamic Psychotherapy

ISTDP is a form of psychotherapy developed by Habib Davanloo in the 1960's that built on the analytic ideas of Sigmund Freud (ten Have-de Labije and Neborsky, 2012). Davanloo's approach to therapy has been refined by later authors; one of the influential forms of ISTDP practised in Europe was developed by Josette ten Have-de Labije and Robert Neborsky (2012). Symptoms in this approach are seen as a result of the conflict between expressing unconscious feelings and defending against them (Della Selva and Malan, 2006). Within this model, the difficulties a client comes for help with are formulated using the two triangles model developed by Malan (1995 in Malan, 2010, figure 1). This model of formulation represents the triangle of conflict and the triangle of person. The triangle of conflict depicts how the client's anxiety and defences repress the hidden feelings and impulses. The triangle of person depicts the client's patterns of relating which were developed with the primary caregiver in childhood and are repeated in the client's current relationships and also with the therapist in the form of transference.

Figure 1: Malan's two triangles formulation (1995, in Malan, 2010)



The client enters the therapy with either anxiety or defences at the forefront. Anxiety within this model is viewed as the physiological symptoms provoked by a rise in the hidden feeling/impulse. Defences are the unconscious psychological strategies implemented to manage the anxiety and keep the hidden feelings unconscious. The hidden feelings originated in the client's childhood relationship with their primary caregiver. The aim when using this approach is to support the client in accessing the conflicting and painful feelings that originated in the relationship with the primary caregiver in childhood. The concept of the ego and superego, originally identified by Freud, are a significant concept within ISTDP. Freud saw the superego as the moral part of personality; he thought that this part of the personality was the last part of the personality structure to develop. Within ISTDP, the superego is considered to play a significant part in the development of neuroses in the first few months of a child's life (Davanloo, 1990, in ten Have-de Labije and Neborsky, 2012). For example, if a child experiences a traumatic experience such as neglect, they may find it difficult to place themselves in a position of importance in relationships and the experience of neglect will be repeated. Due to the nature of difficulties that client's come for help with the superego pathology is often harsh and punitive. The therapist's task in this case is to side with the healthy ego of the client that wants help with the problem against the unhealthy superego that is trying to keep the painful feelings hidden. In order to achieve this, the therapist requires a good understanding of their own personality structures (ten Have-de Labije and Neborsky, 2012).

Using this approach involves understanding how a client's psychological defences and anxiety are designed to keep painful feelings out of conscious awareness. To effectively recognise and challenge a client's defensive structure it is important that the therapist is aware of their own defensive structure. Without this knowledge, a therapist will likely miss when the client uses defences similar to their own or may allow the client's punitive superego to prevent the client from looking at themselves with curiosity and care. This can lead to a misalliance in the therapy. When conducting this therapy the therapist needs to constantly assess whether the client is engaging in a defence, has high anxiety or is responding with feeling. As this is a significant amount of information to assess even a highly trained and experienced ISTDP therapist will miss out on important information in

the session. To manage this all sessions are video recorded with the client's consent to be reviewed between sessions by the therapist. In order to better understand what I was missing in sessions with my clients I would take video recordings to supervision as well as reviewing them myself. Receiving supervision in this model involved practical support, such as how to better assess the client's level of anxiety, as well as support to identify, clarify and confront my own defences that were impacting upon the therapeutic relationship. It was during this process that I became aware that some of the defences I was habitually engaging in with my clients were also activated during the research process. I thought that it was important to explore these defences with both my placement and research supervisors to ensure I conducted my research in an ethical and effective way. Engaging in this process allowed me to recognise when I was using these defences and make a choice as to whether continuing to use that defence would have a negative impact upon the research process. The main defences that were explored throughout the research process were: helplessness, compliance and ignoring.

Defences during the Research Process

Helplessness is where a person takes a passive approach to their difficulties and consequently looks upon themselves in a helpless way (Frederickson, 2013). In instances when I took a helpless view of myself I found it more difficult to solve problems and overcome hurdles that occurred. This defence was identified in supervision early in my placement where the techniques of the therapy felt incredibly different to previous therapies I had delivered. To develop a helpful conscious and unconscious working alliance with the clients I was working with I needed to address defences that I was using that blocked intimacy which was a difficult process where at times I would revert to helplessness. At times when I did not challenge this defence I would view myself as lacking the resources to solve the difficulties that arose. In addition I would experience pressure from a punitive superego that would reinforce the idea that I did not have the skills required for the task. To challenge this defence I also needed to challenge the voice of the superego. I did this by looking at the available evidence regarding my skills and ability, the supervision provided on placement was pivotal in learning the skills to manage this.

The defence of helplessness initially occurred when faced with difficulties in securing ethical approval for the study due to misinformation regarding the order of ethical approvals. This caused significant delays to the project. It was important to challenge this defence at this time as I needed to ensure consistent communication with those involved and seek out further information sources to resolve the problem. If I had not challenged this defence, the research project would have been further delayed and completion of the project on time could have been jeopardised. Once ethical and research and development approvals had been granted, I was able to commence recruitment. It transpired that this was another problematic area. There are a limited numbers of clinical psychologists operating as multi-disciplinary managers in NHS services and there was no straight forward way to obtain the information on who potential participants were and where they worked. To manage this multiple strategies were required to secure enough willing participants. Even with multiple strategies to recruit participants it proved very difficult to identify participants and arrange interviews. At this point in the process, I recognised a pull towards taking a helpless position. However, because of an increased awareness of a tendency to look upon myself in a helpless way I was able to identify this as a defence and recognise the capacity I had to persevere with recruitment and seek further help to identify further participants. Clinical and research supervision proved key in managing this defence, clinical supervision helped to explore the underlying experiences that led to the development of this defence while research supervision provided practical support to overcome difficulties.

The defence of compliance is giving priority to the will of others (ten Have-de Labije and Neborsky, 2012). When engaging in this defence, it means ignoring what I want and instead trying to identify what I think the other person in the interaction wants and try to meet their need. As a therapist, there are indications that the client is engaging in this defence, for example, when asked for their opinion they may say they do not know or look at the floor when asked a question about what they want. This defence was highlighted to me in supervision when I would drop eye contact and look at the floor when asked about my opinion and experience anxiety when trying to identify what I wanted in the situation. In terms of the research process, it was important to be aware of this particularly during

participant interviews. If I allowed myself to see the participant as completely more important than me during the interviews, this would reduce the quality of the information gained during the interview. It would make it more difficult to stick to the interview schedule as I would be following the lead of the participant. In a grounded theory study, it was necessary to maintain a sense of what I needed to test out in interviews in order to assess whether there were themes that needed further exploration. However, this needed to be balanced with being open to ideas that the participants introduced during the interviews and maintaining a balance between what I required for the interview and what participants thought was influential in their stories. This was an area where I recognised how key it was to not only be able to identify the defence of compliance when it arose but being able to make a choice as to whether to continue to use it or not. Compliance also initially had an impact on research supervision. In organising supervision time, I would feel concern for taking up the time of my research supervisor and think of how he would have other tasks to undertake that were more important than my research. When I considered the impact of this, I recognised that this could have a negative impact on being able to complete my research to the standard I wished by not making use of the help offered. By recognising the self-defeating nature of engaging in this defence I was better able to challenge it and both take the offered support and identify what it is I needed from that help.

Ignoring is the defence of not paying attention to the self (ten Have-de Labije and Neborsky, 2012). This is linked to the defence of compliance as it supports the ability to focus on others over the self. Ignoring can take the form of not paying attention to the physiological manifestations of anxiety which then prevents anxiety regulation as well as ignoring feelings or the stimulus that provoked the feelings (Frederickson, 2013). Through supervision, it became clear that I paid little attention to my anxiety when it arose and as a consequence would not take steps to regulate it until it reached a high level. I also had a tendency to ignore my feelings when they arose both in terms of lacking clarity on what had provoked the feeling as well as finding it challenging to identify the physical sensations associated with the feeling. There were several areas where I wanted to manage this differently in relation to conducting the research. Firstly, by ignoring my anxiety I would only become aware of it when it reached a high, and uncomfortable, level.

This had the potential to have a negative effect on my ability to perform when conducting interviews as high anxiety can interfere with cognition and perception (Neborsky and ten Have-de Labije, 2012). This could also have an adverse effect on participants' experience of being interviewed. Ignoring also had an impact on the coding of interview transcripts. This was identified through research supervision where my supervisor pointed out that I had not included particularly emotive aspects of participants' stories into line by line coding. This mirrored the ignoring that occurred when looking at my own feelings. By being aware of this defence I was able to notice more emotive sections of participants' accounts and then consider whether to include that aspect into the coding or not. This helped to manage my own bias within the coding. I sought further supervision both on an individual and group basis to check whether there were other aspects of emotive language I was ignoring. This was done at different stages in the coding - in line-by-line coding where data is coded a line at a time and focussed coding where the line-by-line coding is pulled together into larger sections.

The Process of Increasing Self-Awareness

There were three main defences that had the potential to impact upon a variety of aspects of the research process: helplessness, compliance and ignoring. These defences were initially explored within the clinical environment through supervision using video tapes of therapy sessions. Having my clinical work under such close scrutiny was initially an anxiety-provoking experience, but this was explored within the relationship with my clinical supervisor. When I was able to see the impact of this process it became a valuable way to understand specifically what to do when working with clients and also be able to identify more generally when particular patterns were occurring in my daily life. This provided valuable expertise in recognising the impact of my defences on my research. This enabled me to make an informed choice about whether engaging in the defences had the potential to be detrimental to the study I was conducting. By analysing this I was able to assess the ethics of my approaches to the research at a level beyond that prescribed by the standard ethical codes of conduct. It also supported me in taking care of myself throughout what was a lengthy and arduous research process.

Conclusion

Conducting research has been a challenging process where I had to navigate challenges. As a result of this process I have developed a better awareness of how I respond to difficulties and the importance of utilising available support structures. Through identification of some of my psychological defences through undertaking clinical work and supervision, I was able to recognise when particular defences were in action and make a decision as to whether to challenge the defence or not. By understanding the ISTDP approach I was able to recognise what defences were in action, take better care of my anxiety, and implement strategies to challenge my defences. This helped me to better manage hurdles that occurred during the research process as well as better understand why I experienced certain events more difficult to manage than others. When conducting research in the future, I will proceed with an open mind to the research journey recognising that I have the skills and resources to face traffic and road works and that support is available to help me to find the best diversions for the delays encountered.

References

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE.

Della Selva, P.C. & Malan, D. (2006). *Intensive short-term dynamic psychotherapy: Theory and technique*. GB: Karnac Books.

Frederickson, J. (2013). *Co-creating change: Effective dynamic therapy techniques*. Kansas City: Seven Leaves Press.

Greenwood, P., Ryan, T., Keaveny, J., & Deo, R. (2007). Supporting change: Implementing new ways of working in east Lancashire. *Mental Health Review Journal, 12*(3), 10-14.

Limb, M.K. (2004) Using grounded theory in qualitative health care research. In Bassett, C.C. (Ed.) *Using qualitative research in health care.* London: Whurr Publications.

Malan, D. (2010). *Individual psychotherapy and the science of psychodynamics*. (2nd Ed.) London: Hodder Education.

ten Have-de Labije, J. & Neborsky, R. J. (2012). *Mastering intensive short-term dynamic psychotherapy: Roadmap to the unconscious*. London: Karnac Books.

Appendix 1: List of Papers

Date	Author	Title	Journal	Volume, issue, page	Methodology	Key Findings
2011	Astbury, G., Lovell, A., Mason, T., & Froom, K.	Cultural change in a learning disability secure service: the role of the 'toggle' group	Journal of Psychiatric and Mental Health Nursing	18, 9	Focus groups	Group dynamics important - positive, negative and 'toggle' group that switch dependent upon several factors.
2010	Baker, J., Playle, J., Nelson, P. and Lovell, K.	An evaluation of the impact of the recommendations of the Chief Nursing Officer's (England) Review of Mental Health Nursing in Mental Health Trusts and Universities in England: Findings from Stage One, an e-survey	Journal of Clinical Nursing	19, 17/18, 2590-2600	E-survey	Competing priorities and engagement with too many initiative can reduce engagement with changes. Organisational engagement with changes key
2007	Dickinson, H., Peck, E., Davidson, D.	Opportunity seized or missed? A case study of leadership and organizational change in the creation of a care trust	Journal of Interprofessional Care	21, 5, 503-513	Case study	Long history of health and social care services working together. Too much consensus can inhibit innovation. Leadership and communication important
2014	Evans, N.	Improving the timeliness of mental health assessment for children and adolescents in a	International Practice Development Journal	4, 1, 1-13	Action research, SS interviews, wait list, survey	Action research support change by engaging staff

		multidisciplinary team				
2007	Greenwood, Paul	Supporting Change: implementing New ways of working in East Lancashire	Mental Health Review Journal	12, 3, 10-14	Case study	Communication between teams to encourage MDT approach, more negative views expressed in a group, IT systems should be fit for purpose.
2013	Kelly, M., Humphrey, C.	Implementation of the care programme approach across health and social services for dual diagnosis clients	Journal of Intellectual Disabilities	17, 4, 314-328	Semi structured interviews, documentary analysis	Difficulties where change across two different services, contextual factors affected change and targets can increase uptake.
2009	Khandaker, G., Cherukuru, S., Dibben, C., Ray, M.K.	From a sector-based service model to a functional one: Qualitative study of staff perceptions	Psychiatric Bulletin	33, 9, 329-332	Interviews	Staff have positive and negative thoughts about change, significant concerns on impact of patient care and caseloads. Communication key solution
2011	Lewis, A., Ilot, I, Lekka, C., Oluboyede, Y.	Improving the quality of perinatal mental health: a health-visitor led protocol	Community practice	84, 2, 27-31	interview, focus group, observation	Key staff as drivers, responsive to local need, continuity of clinical and operational leadership
2008	Riley, A.J., Bing, R., White, C., Smith, S.	Utilising theories of change to understand the engagement of general practitioners in service improvement: a formative evaluation of the Lewisham Depression Programme	Quality in Primary Care	16, 1, 17-26	Formative evaluation	Variety of organisational factors influence engagement with the programme such as communication from manager and meeting with facilitators of programme.

Appendix 2: University Ethical Approval

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	Sarah Bromilow
Title of Study:	**Clinical Psychologists as Multi-Disciplinary Team Managers – A Grounded Theory Study.**
Award Pathway:	**DClinPsy**
Status of approval:	**Approved with conditions**

Action now needed:

Your proposal has now been approved in principle by the Faculty's Ethics Panel. This is dependent on your obtaining and presenting to the panel a letter of support from the R&D Department of the N HS Trust within which you will be conducting your research.

Following this, you will not need to approach the Local Research Ethics Committee. You shou d note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You shou d arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation

Comments for your consideration:

Please forward the requested letter of support at you earliest convenience to Andrea Boardman, Clinical Psychology, Science Centre, ST4 2DF or email a scanned, signed copy to healthsciencesethics@staffs.ac.uk.

pp **Signed:** Professor Vish Unnithan — **Date:** 19th March 2014
Chair of the Faculty of Health Sciences Ethics Panel

Appendix 3: Ethical Approval Following Amendments

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Sarah Bromilow**
Title of Study:	**Clinical Psychologists as Multi-Disciplinary Team Managers – A Grounded Theory Study.**
Award Pathway:	**DclinPsy**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to your recruitment process. I understand that you need to widen the pool of potential participants and in order to do so, you intend to:

1) Ask the Leadership and Management Faculty of the Division of Clinical Psychology in the British Psychological Society to email members of the group to generate potential participants.
2) You would then go through the research and development team of the NHS Trusts that participant works for in order to gain permission to interview the participant

This amended process is approved.

Action now needed:

Your amendment has now been approved in principle by the Faculty's Ethics Panel.

Following this, you will not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

Signed: Prof Karen Rodham **Date:** 7th October 2014
Chair of the Faculty of Health Sciences Ethics Panel

Appendix 4: Example of Research and Development Approval

[redacted]

NHS Foundation Trust

[redacted]

[redacted]

Date: 25 September 2014

Ms Sarah Bromilow
Trainee Clinical Psychologist
Psychology Department
Trust HQ
St George's Hospital
Stafford ST16 3AG

Dear Sarah

Study title: Clinical Psychologists as Multi-Disciplinary Managers

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the University Ethics dated 19 March 2014, which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

[redacted]

Appendix 5: Participant Information Sheet

TITLE
Clinical Psychologists as Multi-Disciplinary Team managers – a grounded theory study

INVITATION
You are being asked to take part in a research study on clinical psychologists who have taken jobs within the NHS as managers of multi-disciplinary teams. The research aims to develop a theory, or set of theories, about clinical psychologists in this job role. The areas that will be explored will be why the move was made from practitioner to manager, the impact of a psychological background and whether the psychological background has an impact on the service and service users.

The study will form part of the Doctorate in Clinical Psychology at Staffordshire and Keele Universities. The research will be supervised within the Staffordshire University team by Professor Helen Dent, Programme Director of the Doctorate in Clinical Psychology at Staffordshire University. The project will be approved by the Staffordshire University Ethics panel. Approval will also be obtained from the Research and Development Department of your employing Trust.

Procedure
In this study, you will be asked to consent to a semi-structured recorded interview exploring your experiences as a qualified clinical psychologist who moved into a multi-disciplinary management role. Three topic areas will be explored: reasons for the transition, impact of a psychological background and whether this has an impact on the service that you work in and the service users this involves.

The interviews can take place within your place of work subject to availability of a room that will provide a comfortable environment for the interviews to take place. The interviews will be recorded to enable transcription and analysis. The information will be analysed and theory/theories constructed around the data. Once the study is completed, a copy can be requested for your perusal.

TIME COMMITMENT
It is anticipated that the interviews can be completed within one session lasting approximately 60 minutes.

RIGHTS
You have the right to withdraw from the study at any time without providing an explanation. Prior to publication of the study, you can request for the information you provided to the study to be destroyed. You also have the right to refuse to answer any question asked without explanation.

Any questions that you have about the study will be answered as fully as possible. If after reading the information sheet you have further questions, the researcher can be contacted to answer these prior to consenting to the study.

BENEFITS/RISKS
There are no known risks for you in this study. Whilst the study may not be of personal benefit, it may provide a benefit to the profession through starting to build evidence for the role of clinical psychologists in managing services.

COST
Your participation in this study is voluntary. There should not be any cost in this study except in terms of time spent participating in the interview.

CONFIDENTIALITY/ANONYMITY
The data collected will be based around your personal experiences and limited personal information will be obtained and only with your consent. Whilst every effort will be made to ensure confidentiality and anonymity throughout, due to the small number of participants in the study it cannot be guaranteed that you could not be identified by those you work closely with professionally. Each participant will be given a code to identify their data which will be stored securely. Quotes may be used in the completion of the full thesis report, unless you choose not to consent to this.

When the study is completed, publication in an appropriate journal will be sought. All identifiable information will be removed from the full report of the study to limit identification of participants.

All data gathered will be stored securely. Information stored electronically will be held on a password protected computer. All physical information will be stored in a locked box. Staffordshire University requires that all data gathered for research must be stored securely by the university for ten years before it is destroyed.

FURTHER INFORMATION
The researcher is glad to provide any further information on this study as required. In addition, the supervisors of this project can be contacted for further details:

Professor Helen Dent

Tel: 01782 294007

E-mail: H.R.Dent@staffs.ac.uk

If you wish to receive a copy of the final report of this study, you can let the researcher know at the time of interview. In addition, the researcher can be emailed to request this on the following address:

Sarah Bromilow

E-mail: b027437b@student.staffs.ac.uk

Appendix 6: Consent Form

Participant Number:

Clinical Psychologists as Multi-Disciplinary Team Managers – A grounded theory study

The study aims to explore different aspects of clinical psychologists as multi-disciplinary team managers using semi structured interviews. The study will focus on three areas: reasons for change from practitioner psychologist to multi-disciplinary manager, impact of a psychological background and the impact of a psychological background on the service and service users.

Please initial all boxes

I have read and understood the information and consent sheets	☐
Any questions I have about the study have been answered	☐
My participation in the study is voluntary and I can withdraw from the study at any time	☐
Quotes from the interview can be used in the study	☐

Participant

Print _____

Signature _____

Date _____

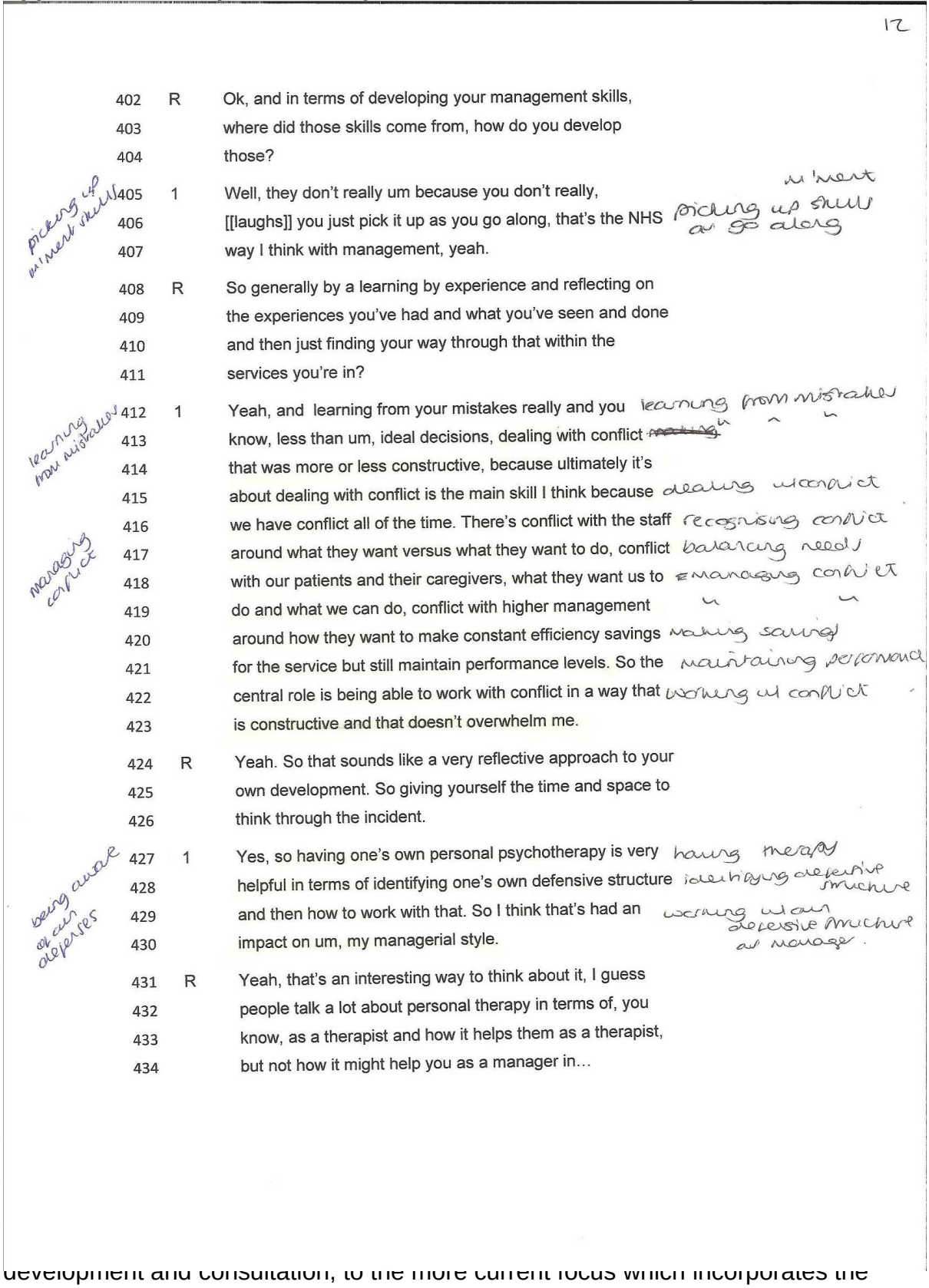
Appendix 7: Interview Guide

- 1. Can you talk me through your progression from clinician to manager?
- Sub-question- What specific factors led you to make the decision to move into management?
- Sub-question- At what point did you make the decision to move into management?
- Sub-question- Tell me about what influences you as a manager
- 2. How does your background in psychology impact your management?
- Sub-question- What from your clinical psychology training impacts your management practice?
- Sub-question- What from your experience of practicing psychology has influenced your management practice?
- 3. Tell me about the impact of your psychology background on the service that you manage
- Sub-question: What psychological approaches do you utilise in your practice?
- Sub-question: What further training have you undertaken?
- Sub-question- What do you consider are the advantages to your psychological background for the service?
- Sub-question- What about the disadvantages to a psychological background for the service?
- 4. Considering the clients using your service, what influence do you feel your psychological background has?
- Sub-question- How do you think your background could be beneficial to the users of your service?
- Sub-question- What could be the drawbacks to the service users?
- 5. Is there anything else that you think it would be of benefit to discuss?

At relevant points, responses will be followed up with appropriate prompts such as the following:

- Can you provide an example of that?
- Tell me more about that
- Can you explain that further?
- What do you mean by that?

Appendix 8: Example of Line-by-Line and Focussed Coding



12

402	R	Ok, and in terms of developing your management skills,
403		where did those skills come from, how do you develop
404		those?
405	1	Well, they don't really um because you don't really,
406		[[laughs]] you just pick it up as you go along, that's the NHS
407		way I think with management, yeah.
408	R	So generally by a learning by experience and reflecting on
409		the experiences you've had and what you've seen and done
410		and then just finding your way through that within the
411		services you're in?
412	1	Yeah, and learning from your mistakes really and you
413		know, less than um, ideal decisions, dealing with conflict
414		that was more or less constructive, because ultimately it's
415		about dealing with conflict is the main skill I think because
416		we have conflict all of the time. There's conflict with the staff
417		around what they want versus what they want to do, conflict
418		with our patients and their caregivers, what they want us to
419		do and what we can do, conflict with higher management
420		around how they want to make constant efficiency savings
421		for the service but still maintain performance levels. So the
422		central role is being able to work with conflict in a way that
423		is constructive and that doesn't overwhelm me.
424	R	Yeah. So that sounds like a very reflective approach to your
425		own development. So giving yourself the time and space to
426		think through the incident.
427	1	Yes, so having one's own personal psychotherapy is very
428		helpful in terms of identifying one's own defensive structure
429		and then how to work with that. So I think that's had an
430		impact on um, my managerial style.
431	R	Yeah, that's an interesting way to think about it, I guess
432		people talk a lot about personal therapy in terms of, you
433		know, as a therapist and how it helps them as a therapist,
434		but not how it might help you as a manager in…

development and consultation, to the more current focus which incorporates the previous training with an integration of management and organisation training.

However, where there is an interest in moving into management or a stimulus, such as frustration, this seems to have been negated in the decision process.

The time at which people became qualified seems to have had an influence on what type of opportunities were available. As services were changing and developing for example, IAPT development, different positions and ways of working started to develop. Depending on people's experiences this seemed to widen or narrow opportunities to move into management or leadership roles. Time also seems to have impacted perception of psychology, focus of services, threat, finances etc.

How do people experience this across Trusts? Do different types of services present different opportunities and deal with the difficulties differently? Do participants recognise changes across time?

Added: 12/02/2015

Time seems to interact with Trust priorities, some Trusts seem to have a focus to move away from psychologist managers due to the expense of the resource and not wanting to lose the psychologist as a therapist. Other Trusts seem to have a focus on leadership development and see psychology as being in a senior role and so useful in developing and leading services as well as supporting operational procedures such as investigations and conflict management. This seems to be embedded in the Trust culture and as a result procedures to support and develop managers seem to be in place. For example, leadership training opportunities, allowing psychologists to recruit for the teams they will run.

There also seems to be an issue regarding financial constraints and how this influences the way services are structured. The financial changes over the past few years have led to a lot of organisational change, which different Trusts have responded to differently, for example, moving from several smaller teams, managed by psychologists, to larger streams, not run by psychologists.

Aside from these factors it seems as though participants have been motivated to work around the obstacles in the organisations and the factors seem to vary across participants. The motivation seems to be an interest or a drive to lead, manage or develop services or a decision to secure a job they enjoy at a wage they felt was fair

except where the initial decision was initiated by the organisation, then these factors come later or maintain interest in the role.

Appendix 10: Author Guidelines for the Journal of Change Management

Manuscript preparation

1. General guidelines

Manuscripts are accepted in English. Oxford English Dictionary spelling and punctuation are preferred. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of words or more should be indented without quotation marks. There should be no references/citations to other works in the Abstract. All articles should preferably be written in the third person and must be presented with clear 'Introduction' and 'Conclusion' sections. The Introduction should clearly state purpose and contribution.

A typical manuscript will not exceed 8500 words including references and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.

Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Abstracts of words are required for all manuscripts submitted.

Each manuscript should have to keywords.

Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.

Section headings should be concise.

All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.

All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.

Please supply a short biographical note for each author.

Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:

> *For single agency grants:* "This work was supported by the [Funding Agency] under Grant [number xxxx]."
>
> *For multiple agency grants:* "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."

Authors must also incorporate a SI units. Units are not italicised.

When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Authors must not embed equations or image files within their manuscript

2. Style guidelines

Description of the Journal's article style.

Description of the Journal's reference style.

Guide to using mathematical scripts and equations.

3. Figures

Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

Figures must be saved separate to text. Please do not embed figures in the manuscript file.

Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).

Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.

The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Appendix 11: Author Guidelines for the British Journal of Clinical Psychology

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing

All manuscripts must be submitted via http://www.editorialmanager.com/bjcp/. The Journal operates a policy of anonymous peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.
4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from here.
• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining

cautions or limitations of the study. They should be placed below the abstract, with the heading ‘Practitioner Points’.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.